

KNOWLEDGE, ATTITUDES AND RISK BEHAVIOURS OF ADOLESCENT GIRLS IN  
RELATION WITH HIV/AIDS AND CONDOM USE IN CATHOLIC SCHOOLS IN MANZINI

by

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## DEDICATION

*In memory of my late mother Mrs. Marie Ngono  
who always guides me to be “me” in every situation.*

**Student number: 35507994**

### **DECLARATION**

I declare that **KNOWLEDGE, ATTITUDES AND RISK BEHAVIOURS OF ADOLESCENT GIRLS IN RELATION WITH HIV/AIDS AND CONDOM USE IN CATHOLIC SCHOOLS IN MANZINI** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE

(MRS B V ZANGA BITCHONG

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DATE

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My gratitude first goes to the Almighty for providing me strength, patience and spiritual support I truly needed to complete this study.

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# **KNOWLEDGE, ATTITUDES AND RISK BEHAVIOURS OF ADOLESCENT GIRLS IN RELATION WITH HIV/AIDS AND CONDOM USE IN CATHOLIC SCHOOLS IN MANZINI**

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## **ABSTRACT**

A descriptive correlational study aiming at describing the knowledge, attitude and risk behavior of adolescents in relation to HIV/AIDS in one “girls only” Catholic school of Manzini. Structured self-administered questionnaires were used to collect data from 260 respondents aged 12 to 19 years.

Although only 22.31% respondents indicated been tested for HIV, (83.08%) would like to take an HIV test. Hospital and clinic are mostly known by respondents for providing HIV testing. Most respondents expressed lack of confidence in getting partners wear condoms. 16 (6.15%) have engaged in sex and 5 (6.10 %) were raped. No statistically significant difference was noted between condom use during sexual intercourse for both participants who were raped and those who consented to sex (P value = 0.6538). Future youth health programs should focus on building confidence of youth in accessing condom, discussing condom issues with their partners and make their partners wear condoms.

### **KEY CONCEPTS:**

Adolescence; early sexual activities abstinence; HIV, condoms, attitudes; behavior; knowledge; risk factors.

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# **CHAPTER 1**

## **ORIENTATION TO THE STUDY**

### **1.1. INTRODUCTION**

The first case of HIV was detected in Swaziland in 1987, since then the pandemic continues to rise and now the Kingdom of Swaziland is considered the epicenter for HIV (NERCHA & MOHSW, 2009: 2). The HIV prevalence rate among the adult population is 26, 2 per cent, the highest in the world (Swaziland Central Statistical Office and Macro International Inc. 2008: 221). The effects of HIV is felt at all sectors; in the health sector, mortality has tripled among the adult population (from about 8 deaths per thousand in 1994 to about 23 per thousand in 2004) (Whiteside, Andrade, Arrehag, Dlamini, Ginindza and Parikh, 2006: 9). Hence the King of Swaziland, Mswati III declared HIV a 'National disaster' (IRIN, 2008).

In Swaziland, HIV prevalence among young people of 15-24 years is at 31 % (Swaziland Central Statistical Office and Macro International Inc. 2008: 222). Young women are disproportionately affected by the HIV pandemic by as much as twice compared to their male counterparts, 22.6 % and 5.8 % respectively (WHO, UNAIDS, UNICEF, 2008: 5). One of the essential interventions for preventing the spread of HIV/AIDS among the youth is sex education, aimed at promoting positive attitudes, perceptions and behaviors (ADVERT, 2012: 3). Evidence from western countries and in some African countries like Uganda has demonstrated that comprehensive sexual education focusing on "preventing gender-based violence, promoting safer sexual practices and observing the rights of citizens is effective in minimizing the risk of HIV/AIDS" (Boonstra, 2011: 2 ).

Much as sexual education can be beneficial in promoting safer sexual practices, opponents to this view may insist on 'abstinence from sexual intercourse' as the ideal preventive strategy in curbing HIV infection among youths (Collins, Alagiri, Summers, 2004: 8). Similarly, in the Christian community, reproductive health education and safer sexual practices may not be promoted (Euteneur, 2009). Such approach to reproductive health

education may deny students the opportunity to access accurate information about safe reproductive health and increase their risk of acquiring HIV infection (Boonstra, 2011: 3).

A situation analysis of the knowledge, attitude and risk behaviors of adolescent girls in relation with HIV/AIDS in catholic “girls only” school of Manzini would identify gaps in HIV preventive programmes. The proposed study is aimed at identifying knowledge gap that may exist among adolescents’ girls about HIV infection, explore attitudes and behaviors, which may put them at risk of acquiring HIV infection.

## **1.2. BACKGROUND TO THE RESEARCH PROBLEM**

### **1.2.1. Statement of the research problem**

Young people aged 15 to 25 are the most vulnerable group to HIV infection in Swaziland (Swaziland Central Statistical Office and Macro International Inc., 2008). Early sexual debut is one of the factors responsible to HIV infection among young people, as they are still sexually immature (NERCHA & MOHSW, 2009: 25). The Swaziland Health Survey of 2008 reported that about 50 % of young people aged 15 to 24 years had initiated sexual intercourse by the age of 18 years (Swaziland Central Statistical Office and Macro International Inc. 2008: 221). Ineffective sexual education among families, communities and schools may contribute to the HIV infection (UNESCO, 2009: 13). It is therefore important to identify factors responsible for lack of knowledge about HIV preventive measures among adolescent in an effort to reduce HIV infection in the population.

Swaziland remains the country with the world highest HIV/AIDS prevalence in the world with 26.2 percent of HIV prevalence among adults aged 15 to 49 (Swaziland Central Statistical Office and Macro International Inc. 2008:221). By the end of 2007, HIV and AIDS had killed about 10 000 adults and children and left 56 000 orphans who may also acquire HIV due to their socio-economic situation (WHO, UNAIDS, UNICEF, 2008: 5). Orphans and vulnerable children (OVC) account for a fifth (200 000 OVC) of Swaziland's roughly one million people (Youth Education farm, 2012: 2).

In addition, there is increased absenteeism from work due to HIV related morbidity, HIV has depleted resources for supporting health services, social security, education and economic aspects of private and public sectors, thus increasing fiscal deficits and poverty (Whiteside, Andrade, Arrehag, Dlamini, Ginindza and Parikh, 2006: 23; 2006). The International Monetary Fund (IMF) in IRIN (2012: 5) attributes the current economic and fiscal crisis of Swaziland, in part to HIV/AIDS as investors are reluctant to invest in Swaziland due to decreased productivity, no economic growth and an increased cost of replacing AIDS related deaths among workers. It is estimated that the cost of replacing teachers dying from AIDS would escalate to R2.3 billion by 2019 (IRIN, 2012: 1).

Unsafe (no condom use) heterosexual intercourses are the main mode of HIV transmission among Swazis including the adolescents (NERCHA & MOHSW, 2009: vii). Early sexual debut are a norm, yet adolescents lack factual knowledge about sexuality and HIV prevention (WHO, UNAIDS, UNICEF, 2008:12). Besides, there is evidence that young immature girls (below the age of 18) are likely to engage in sexual intercourse without using a condom to prevent HIV infection because of their low status (WHO, UNAIDS, UNICEF, 2008:12). In Swaziland, about 47 % of adolescents' girls did not use a condom on their first sexual intercourse (Swaziland Central Statistical Office and Macro International Inc. 2008: 207).

The International Planned Parenthood Federation (IPPF, 2009: 6) asserts that adolescents should receive factual sexual education in an effort to prevent HIV transmission. Factual knowledge about sexuality can enhance positive attitudes and behavior which will ultimately reduce adolescent risk to HIV and other sexually transmitted infections (Kambole, 2007: 8). In the same line most ongoing HIV prevention interventions in Swaziland aim at changing knowledge, attitudes and beliefs on HIV related issues (NERCHA & MOHSW, 2009: viii). The government has established The Swaziland National Youth Council (SNYC) as a national response to HIV/AIDS targeting the youth (IPPF, UNFPA, The Global Coalition on Women and AIDS, 2012: 7). There are also a number of other organizations that provide youth friendly services, including School Health Education Program (SHAPE), The Family Life Association of Swaziland (FLAS), the Church Forum and Community Based Organizations (NERCHA & MOHSW, 2009: 5). Most of these organizations focus on youth

interpersonal education-related-interventions, family life education, prevention education and counseling and condom promotion (WHO, UNAIDS, UNICEF: 2008: 12).

HIV and life skills education have also been integrated in the country's education system in an attempt to reduce HIV infection among young people. According to the deputy Director of St Theresa, the Catholic "Girls only" school of Manzini where the study took place, teachers provide biology lessons that include STI's, HIV and AIDS; they also provide related topics such as sexual abuse, etc. (Dupont, 2013. Personal interview. 2 February. Manzini). It also transpired from the discussion that Catholic missionaries regularly conduct sexual education workshops or seminars to adolescents, but the emphasis is on promotion of abstinence as a prophylactic measure to HIV infection. Despite these efforts, myths, misconceptions and culture still constitute a serious obstacle for the effectiveness of the various preventive strategies (Boonstra, 2011: 3).

Moreover there is paucity of scientific research which has demonstrated the effectiveness of educating young girls about abstinence, most programs in Africa (cultural, religious and HIV prevention programs) aim at encouraging young people to maintain virginity by abstaining from sexual intercourse until they are married (Boonstra, 2011: 3). The Roman Catholic religion is no exception to this teaching. With the high rate of HIV/AIDS among young people in Swaziland as well as the lack of evidence that support the effectiveness of "abstinence only" sexual education, it is important to investigate the knowledge, attitude and behavior of adolescent girls in relation with HIV/AIDS as the researcher could not trace studies of adolescence and sexuality focusing on Catholic school female students.



### **1.2.2. Research purpose**

The purpose of this research is to describe the knowledge, attitude and risk behavior of adolescents in relation with HIV/AIDS and condom use in one “girls only” catholic schools in Manzini

### **1.2.3. Research objectives**

**The objectives of the study are to:**

- Assess the knowledge adolescents have regarding HIV prevention strategies;
- Identify sexual behaviors which may increase adolescents’ risk of acquiring HIV infection;
- Evaluate attitudes of adolescents that may increase their risk of acquiring HIV infection;
- Determine factors that may increase adolescents’ risk of acquiring HIV infection.

### **1.3. SIGNIFICANCE OF THE STUDY**

The study will contribute to the existing body of knowledge on adolescent sexual risk to HIV infection in religious institution as there is paucity of research in these institutions.

The results of the study will help sexual and reproductive health programs to strengthen educational programs for adolescents. School curriculum on reproductive health can be reviewed to address gaps identified in this study. Health care providers may use some of the recommendations from this study, to improve sexual reproductive health programs. Parents and community members can use the findings of this study to improve communication related to adolescent reproductive health.

This study will also contribute to the body of knowledge of health care professionals who will ensure that individuals, adolescent, families are knowledgeable about safe sexual practices that prevents HIV infection.

#### 1.4. DEFINITION OF CONCEPTS

**1.4.1. ADOLESCENCE:** The term adolescence is commonly used to describe the transition stage between childhood and adulthood (Wikipedia, 2012: 1).

**1.4.2. ADOLESCENT PREGNANCY:** Adolescent pregnancy means pregnancy in a woman aged 10–19 years which is often associated with limitations to further education, improving the living conditions and increases vulnerability to HIV and AIDS (WHO, 2012).

**1.4.3. EARLY SEXUAL ACTIVITIES:** It refers in general to involvement in sexual activities before 18 to 20 years of age (UNESCO, 2009: 13).

**1.4.4. ABSTINENCE:** Sexual abstinence is the practice of refraining from some or all aspects of sexual activity for medical, psychological, legal, social, philosophical or religious reasons. It can also be done out of choice regarding one's mind, body, and sexual health (Advocates for Youth, 2009: 2).

**1.4.5. CONTRACEPTION:** The intentional prevention of conception by interfering with normal process of ovulation, fertilization and implantation through the use of various devices, sexual practices, chemicals, drugs, or surgical procedures. Contraceptives such as condoms have the double benefit to prevent sexually transmitted infections and pregnancy (Save the children: 2012: 6).

**1.4.6. STI: (Sexually transmitted infections):** are infections generally acquired by sexual contact or kissing. The organisms that cause sexually transmitted infections may pass from person to person in blood, semen and other bodily fluids (Kaiser Foundation, 2006: 5).

**1.4.7. HIV:** is Human Immunodeficiency Virus, the virus that causes AIDS. **AIDS** is Acquired Immune Deficiency Syndrome, a clinical condition that results from long term infection with HIV (Kambole, 2007: 5).

**1.4.8. ATTITUDE:** An attitude can be defined as a positive or negative evaluation often based from one's emotions, and beliefs of people, objects, event, activities, ideas, or just about anything in your environment that can create an inclination for action. (Kambole, 2007: 4).

**1.4.9. BEHAVIOR:** The actions or reactions whether good or bad of a person or animal in response to external or internal stimuli. It is also the manner in which something functions or operates (Salati: 2004: 8).

**1.4.10. KNOWLEDGE:** It is a familiarity with someone or something, which can include facts, information, descriptions, skills, values and expert insight acquired through experience or education that provides a framework for evaluating and incorporating new experiences and information (Salati, 2004: 7).

**1.4.11. RISK FACTOR:** is harm that is caused by some specific danger or threat. These factors exist before a problem arises or continue over time. A community or the general environment can contribute towards the problem (Kambole, 2007: 5).

## **1.5. FOUNDATION OF THE STUDY**

### **1.5.8. Theoretical framework**

The theory of this study is the Theory of Reasoned Action as discussed in Chapter 2: the review of literature.

## **1.6. RESEARCH DESIGN AND METHOD**

This study is a quantitative, descriptive correlational research design (cross sectional and prospective). It is a self-administered questionnaire- based and descriptive study carried at St Theresa, the “only girls” Catholic school of Manzini (Swaziland). The sample design employs a probability sampling approach using a stratified (using Forms as Strata) sample of young people aged 12 to 19 years in St Theresa. The first strata is constituted of girls of

Form I, II and IV; and the second strata is composed of girls of Form IV and V. The study uses a structured and scientific data collection approach and Epi info 7 for data analysis.

### **1.7. SCOPE AND LIMITATIONS OF THE STUDY**

- The population of the school is large (approximately 423 students) resulting in a big sample that may pose challenges for data collection. This is mitigated by administering self-questionnaires in groups.
- The data collection instrument (questionnaire) used presents a risk of information bias that was avoided by having simple and easy to understand multi-choice questions, having the researcher around to clarify questions and reassuring the students of the anonymity and confidentiality of the information.
- Descriptive designs generally are not strong for inference to the population due to the absence of the analytic component. This study was done only on one “girls only” catholic school in Manzini, thus the findings of this study cannot be generalized to all the “girls only” schools of Swaziland. The finding of this study can only form the basis for more analytic and qualitative studies that will go more in dept.

### **1.8. STRUCTURE OF THE DISSERTATION**

**CHAPTER 1: Orientation of the study** that includes the research problem, and the background of the research problem, the aim of the study, the significance of the study, definition of terms, the foundation of the study, the research design and method, the scope of the study and the structure of the dissertation.

**CHAPTER 2: Literature review**

**CHAPTER 3: Research design and method** that include a detailed research design and method and the internal and the validity of the study.

**CHAPTER 4: Analysis, Presentation and Description of the research findings** that include data management and analysis, research results and the overview of the research findings.

**CHAPTER 5: Conclusion and recommendations** that include a summary of the research design and method, summary and interpretation of the research findings, conclusions, recommendations, contributions of the study and limitation of the study.

**CHAPTER 6: References Tables, Figures and Appendixes**

## **1.9. CONCLUSION**

The discussion above provides an overview of the plan on how the research project was attempted. The background to the study, the problem statement, aim and objectives of the study, as well as the significance of the study has been discussed. And lastly research design and methods, scope and structure of the dissertation study have also been outlined.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1. INTRODUCTION**

This chapter provides an overview of HIV, HIV and adolescence in the world and in Swaziland, HIV and the theory used for this study, knowledge, attitudes and sexual behaviours of adolescents by different scholars in the study of HIV/AIDS, HIV/AIDS and adolescence. The literature review will identify the main concepts in the study which includes HIV/AIDS knowledge, attitudes and factors that influence risky sexual behaviours. Possible intervention programmes that have been recommended will be considered, forming a departure point in this study.

#### **2.2. OVERVIEW OF HIV/AIDS**

Since the first cases of HIV were reported in 1981 in the United States of America, HIV/AIDS has rapidly spread all over the world, statistics from the World Health Organization in 2006 show that an estimated 38.6 million people were living with HIV/AIDS worldwide and 25 million have already died of the disease (WHO, 2012: 1). Although the number of new infections has relatively declined through the years, a highly significant number of approximately 34 million people in the world were still living with HIV in 2011 (WHO: 2013:1). Sub-Saharan Africa is the most affected region with nearly 22.9 million of people living with HIV/AIDS in 2011, accounting approximately for 69% of the global number of people living with HIV (UNAIDS: 2013:1); Whereas Western and central Europe only had 840 000 people living with HIV/AIDS in 2011 (AVERT, 2012: 2). Young people are the most infected by HIV and this is a big concern for sub-Saharan-African countries as most of their populations are youthful (UNAIDS: 2013:1). This section presents a literature review of the situation of HIV/AIDS and adolescence in the world and in Swaziland as well as the worldwide prevention strategies; including prophylactic measures undertaken in Swaziland and at Saint Theresa High school.

### **2.3. HIV/AIDS AND ADOLESCENCE: OVERVIEW**

The term adolescence is commonly used to describe the transition stage between childhood and adulthood (Wikipedia, 2012). Researchers are unanimous that it is a transitional stage of significant physical and psychological changes of a person (Kaiser Foundation, 2003: 4). However the beginning and the end of that transitional period varies from one country to another and from one function to another. Many researchers and developmental specialists in the United States of America (USA) for example use the age span 10 – 24 years as a working definition of adolescence (USA Office of Population affairs, 2008) while the World Health Organization (WHO) defines adolescence as young people aged from 10 to 19 year old (WHO,) in Swaziland, young people from 12 to 19 years are considered as adolescents (Swaziland Central Statistical Office and Macro International Inc. 2007: 183, 276).

Because of their psychological and emotional immaturity, poverty and other social factors, adolescents are usually involved in risky behavior such as alcohol drinking, drugs, having unprotected sex, early sexual activities that often result to HIV/AIDS, STI's and unwanted pregnancies (Mngadi, 2007: 9). Unprotected sex is the main cause of HIV/AIDs spread among adolescents in the world (WHO, 2012). UNAIDS considers young people aged from 15 to 24 year old to be the age-group "most threatened by HIV/AIDS" (Boonstra, 2007: 2). Around the world, 5 million young people are living with HIV, with the vast majority (3.8 million/76 percent) living in Sub-Sahara Africa (Advocates for youth, 2011: 1).

However, Young women are especially vulnerable to HIV infection as they have less access to and control over resources (Women deliver, 2013: 2). In fact the leading cause of death among women of reproductive age is HIV/AIDS (WHO, 2009). Young women are often unable to talk with their sexual partner about abstinence, faithfulness, and condom use (Women health, 2011: 1). They also face sexual and physical violence and lack education and economic security (WHO, 2013: 2). This susceptibility makes sex work and intergenerational sex more common, thereby increasing chances of HIV infection (Women deliver, 2013: 2).

## **2.4. HIV AND ADOLESCENCE IN SWAZILAND**

### **2.4.1. Youth's HIV situation**

In Swaziland, 43.5% of the population is below 15 years old (NERCHA, MOHSW, 2009: 19), such a youthful population constitutes a big apprehension for the country's government as youth's HIV prevalence is the highest at 31 % (4124 young people) of 15-24 aged-population living with HIV infection (Swaziland Central Statistical Office and Macro International Inc., 2008: 222). In Swaziland, the HIV prevalence among adolescent girls aged 15–17 years is more than four times higher than among their male peers at 6.2 percent/1.4 percent and 6.1/1.6, respectively (UNICEF, 2013: 1).

### **2.4.2. Impact of HIV/AIDS among young people**

All people living with HIV including young people often suffer from tremendous emotional and medical problems (Salati, 2004: 10). As a result of the HIV infected person's failing immunity, a number of opportunistic diseases (respiratory diseases, dermatological conditions, other sexual diseases, etc.) may appear in the early or advanced stage of the infection (Kambole, 2007: 13). Apart from the emotional draining that often comes with knowing one's HIV positive status, Derek in Dlamini (2007: 33) states that people living with HIV/AIDS mostly in Southern African countries often suffer of self-stigmatization and external stigma they receive from the communities and even health workers. HIV positive young women are however more stigmatized than men (UNICEF, 2013: 2). Simply being identified as HIV positive may result in high discrimination, gender-based violence, unemployment, abandonment or the loss of other human rights and freedoms for young women (IPPF, UNFPA, The global coalition on women and AIDS. 2012: 1). Such young women and girls face grave risks to their education, health, and well-being such as leaving school, anxiety, depression and abuse (UNICEF, 2007: 1). In order to reduce HIV infection, the Theory of Reasoned Action (TRA) used in this study suggests that positive attitudes towards HIV/AIDS preventive strategies could generate the intention to change the behavior leading to the effectiveness of behavior change.

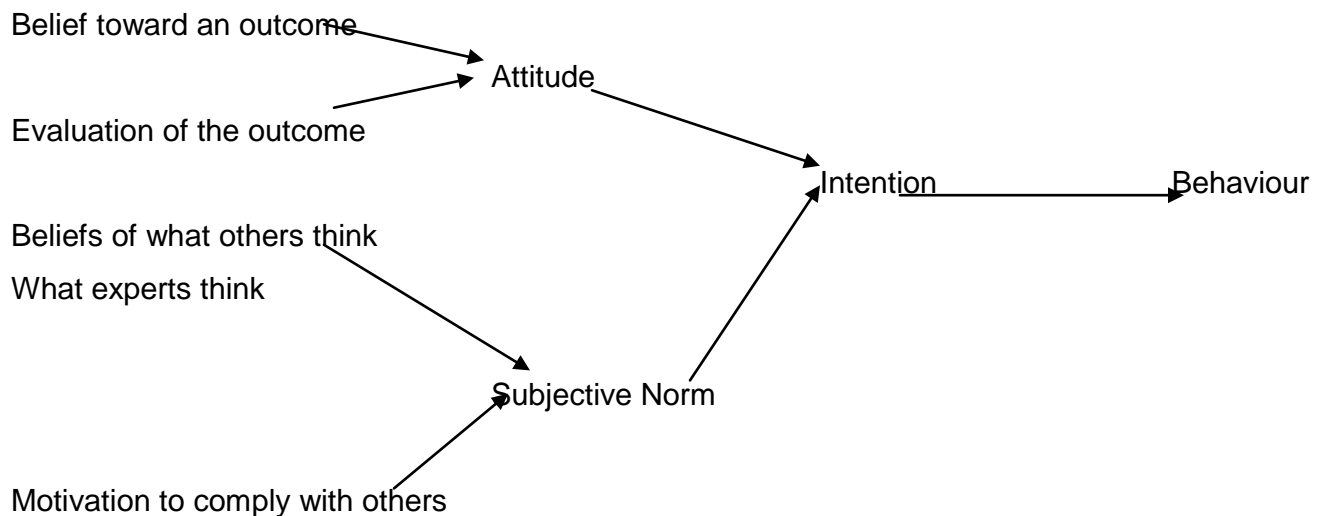


## 2.5. THEORETICAL FRAMEWORK

The Theory of Reasoned Action (TRA) forms the theoretical framework of this study. The theory of Reasoned Action was developed by Martin Fishbein and Icek Ajzen in 1975 and in 1980 as an improvement over Information Integration theory (Theory of reasoned action, 2012: 1).

Ajzen and Fishbein in Kambole (2007: 8) assume that people rationally weigh up the costs and benefits of engaging in an action. They further add that attitudes toward a particular action are influenced by beliefs about the outcome of the action, whether likely or unlikely and evaluation of the potential outcome, whether it would be positive or negative (Kambole, 2007: 8). Gaston adds that the more positive the belief a person has, the more positive the attitude this will create (Gaston, 1994: 1391).

The theory also states that attitudes of significant others, such as professional role models, and motivating factors influence the development of personal attitudes, intentions and beliefs which in their turn influence the outcome of actions or behaviors. (Theory of reasoned action, 2012: 1-4). Clearly, the more one knows about the factors that underlie the performance (or nonperformance) of any given behavior, the more likely it is that one can design a successful intervention to change or reinforce that behavior (Fishbein: 2004: 4). The TRA can be presented in the following way:



(Ajzen & Fishbein, 1980, 62-67)

### **2.5.1. Criticism of the Theory of Reasoned Action**

A wide range of criticisms have been however levelled at TRA including but not limited to the following:

1. It fails to consider the issue of variation in individual's ability both to evaluate the potential consequences of behaviours and utilize these evaluations and that it completely ignores age-related influences and therefore underestimates the issue of peer group influence (Vanlandingham, 1995).
2. There is also limited evidence that AIDS-related knowledge and attitudes shape AIDS-related sexual practices. KAP has been criticized in the light of research findings that increasing people's knowledge about AIDS does not necessarily bring about positive change in their attitudes towards people with AIDS, and importantly does not result in changes in sexual behaviour (Gokengin, Yamazhan, Ozkaya, Sebnem, & Arda, 2003 ; Akande, 2001 ; Uwalaka & Matsuo, 2000 ; Ritieni, Tholandi, Moskowitz, 2000; Otaala, 2000).
3. The TRA model assumes that sexual behaviour is under an individual's conscious control. Sexual behaviour is often not controlled by one individual or one factor only, since there are complex internal and external factors that influence the occurrence of high risk sexual behaviour and impact on an individual's decision-making (Joffe, 1996). It has been documented that sexual behaviours occur in a variety of contexts and is therefore shaped by many factors other than the cognition and intentions of an individual, such as economic, social, cultural factors especially those related to women's position and access to power in patriarchal societies (Rutter & Quine, 2002; Strebel, 1995).

Despite the criticisms raised against the TRA model, this theory has been used as the basis or points of departure for numerous studies (Simelane, 2005: 22). In addition The Theory can be useful in designing strategies to help people to adopt healthy behaviours and to help clinicians increase their uptake of guidelines (Francis, Eccles, Johnston, Walker, Grimshaw, Foy, Kaner, Smith, Bonetti, 2004: 5). In line with Ajzen and Fishbein's (1980) proposition of a direct relationship between behavior and intentions, most of the condom use research that

applied the theories of reasoned action and planned (a model of TRA) behavior reported a direct relationship between condom use intention and behavior (Tlou, 2009: 68).

### **2.5.2. Conceptual Definition of attitudes**

An attitude can be defined as a positive or negative evaluation often based from one's emotions, and beliefs; of people, objects, event, activities, ideas, or just about anything in your environment that can create an inclination for action (Kambole, 2007: 4). It can also be defined as an individual's evaluative positive or negative way of responding to people, views and situations (Ajzen & Fishbein, 1980; Eiser & Pligt, 1988). Fishbein in Greene, Hale and Robin (1997: 22) add that attitudes are personal factors influenced by feelings and beliefs; they function to protect and support one's beliefs and values. Individuals develop attitudes through experiences, information and sometimes attitudes can be self-generated Kambole, 2007:5). Attitudes can therefore be changed by information and experiences since they can be expressed in interaction and action (Eiser & Pligt, 1988). According to Kendra (2013: 1), researchers suggest that elements such as the emotional, the cognitive and the behavioural component can influence attitudes. The emotional component includes the feelings related to an object; the cognitive component comprises the thoughts and beliefs about the subject and behavioural component includes the way the attitude may influence the behaviour.

### **2.5.3. Relationship between knowledge and attitudes**

Knowledge is a familiarity with someone or something, which can include facts, information, descriptions, skills, values and expert insight acquired through experience or education that provides a framework for evaluating and incorporating new experiences and information (Salati, 2004: 7). Ajzen and Fishbein (1980) consider knowledge as one of the components that shape the formation of an attitude. Some studies, like the one done by Okonta and Oseji (2006: 37-39) in Nigeria found that knowledge of HIV/AIDS by adolescents in-school did not significantly influenced the sexual behaviour. Nevertheless, most studies have evidenced that HIV/AIDS's knowledge and related information play a role shaping the attitudes, values and skills that enable adolescents to make responsible choices" regarding their sexual life. For example Swenson et al (2010:1) found in their study on "HIV Knowledge and its Contribution to Sexual Health Behaviors of Low-Income African American Adolescents",

that greater knowledge was associated with sexual behavior. They further concluded that although knowledge might not be sufficiently protective in and of itself, having accurate information about HIV may benefit sexual health by influencing health-promoting attitudes necessary for adopting healthy behavior. Other studies in Belgium, (Rossem, Bertan, Van Tuyckom, 2010:1) and in Malawi (Maluwa- Banda, 2010) reported similar findings in their studies.

## **2.6. KNOWLEDGE, ATTITUDES OF ADOLESCENTS AND RISK BEHAVIORS IN RELATION WITH HIV/AIDS AND CONDOMS USE WORLDWIDE**

UNAIDS (2008: 127) reports that about 40% of males and 36% of female (adults and young people included) had “accurate and comprehensive” knowledge of HIV/AIDS in 64 countries. However, this rate has fallen short of the intended target of 96% of people having adequate knowledge about HIV/AIDS (UNAIDS, WHO, UNICEF, 2008:127,200). In general adolescents have an acceptable knowledge and positive attitudes towards HIV/AIDS preventive strategies in regions where there is financial stability and at a different level, in regions where comprehensive sex education is implemented (Sallar, 2009: 3). In a study done by the Canadian Ministry of education (2003: 130-132), it was found that the majority of Canadian in-school adolescents who had positive attitudes towards preventive strategies are more likely to abstain from sexual relationships or to use condoms constantly. The Ministry further noted that this healthy sexual life was mostly linked to adolescents’ sense of coming from healthy families as well as high self-esteem obtained from comprehensive life skills provided to them. Adolescents living in poor regions like Africa, Latine America and minority communities such as African American in United States and Arboregians in Australia often had lack adequate knowledge about HIV/AIDS as they do not have finances to further their education (Advocates for Youth, 2013: 2) and they are more vulnerable to prostitution and abuse than those coming from wealthy families/communities/countries (Sallar, 2009:2). The Kaiser Foundation (2006: 5) found that drug and substance intakes are one of the main factors that expose young people to HIV/AIDS in America as they regard taking substance as a “normal” thing to do.

## **2.7. KNOWLEDGE, ATTITUDES OF ADOLESCENTS AND RISK BEHAVIORS IN RELATION WITH HIV/AIDS AND CONDOMS USE IN SUB-SAHARAN AFRICA**

Women in general are more prone to HIV infection than men because the semen remain in their bodies after sexual intercourse and their vaginal tracts are less mature and more prone to tearing ((Whiteside, Andrade, Arrehag, Dlamini, Ginindza and Parikh, 2006: 17). Violence and rape also increases the chance of HIV infection for women (Whiteside, 2005:1) as women who are physically, psychologically and sexually abused, usually have serious difficulties to negotiate safe sex (Swaziland Central Statistical Office and Macro International Inc., 2008: 222). Other medical factors such as the presence of other sexual diseases and the early stage of the infection also may put people at risk of HIV infection (Whiteside: 2005: 1). Another important HIV risk factor for young people is drugs; alcohol and other substances intake that often force them to have unprotected sex therefore putting them at risk of HIV infection (Kaiser Foundation, 2006: 6). However unprotected sex remains the main cause of HIV/AIDs spread among adolescents in the world and particularly in Swaziland (WHO, 2012 [page number]). Appropriate preventive strategies are therefore crucial to reduce the HIV spread.

In Sub-Saharan Africa, although most people have heard about HIV, because of inadequate preventive strategies, religious background and myths around HIV, various key elements of HIV are not known (UNAIDS, 2008: 127-200). Prata, Morris, Mazive, Vahidnia and Stehr (2006:194-5) in a study relating individual risk perceptions to the use of condoms in Mozambique reported a high level of knowledge about HIV/AIDS transmission but knowledge on other key elements of HIV/AIDS was significantly low.

People living with HIV/AIDS including young people are often harshly judged, rejected and abandoned and in some cases even killed in Africa (Advocates for youth, 20013: 2). This discrimination is caused by negative attitudes towards people living with HIV. In a study done in Ethiopia on adolescents' attitudes and knowledge towards HIV (Shiferaw, Agersew, Amanuel, Afera, Andarge, Gashaw, Alemu, Teklu, Gelaw 2009), more than 50 % of high school learners included in the sample believed that people living with HIV/AIDs were perceived to be promiscuous and live immoral life, were deserving to be infected with

HIV/AIDS as a form of punishment for their immoral behaviour. Discrimination against PLWHA impacts on testing since young people may be overly concerned about who will see their test results and what can happen to them especially when there is no universal ARV treatment, thus developing in that way negative attitudes towards HIV testing and access to condom (Sallar, 2009: 2-5).

## **2.8. KNOWLEDGE, ATTITUDES OF ADOLESCENTS AND RISK BEHAVIORS IN RELATION WITH HIV/AIDS AND CONDOMS USE IN SWAZILAND**

In the Swaziland Health and Demographic Survey of 2008 , HIV comprehensive knowledge is defined as knowing that: people can reduce their chances of getting HIV by having sex with only the uninfected and by using condoms consistently; a healthy looking-looking person can have HIV; HIV cannot be transmitted by mosquito bites or by sharing food with a person who has HIV. Based on that definition, approximately 50 % of young women and men aged 15 to 19 years had a comprehensive knowledge about HIV/AIDS (Swaziland Central Statistical Office and Macro International Inc. 2008: 221), 2008: 190). However in a study done by Lusweti (2009: 15) with 10511 youth respondents in 64 high schools in Swaziland, overall knowledge of basic facts about HIV was high with over 75% of the sample having correct knowledge about basic knowledge (transmission, protection of HIV and treatment for AIDS). According to the Swaziland Health and Demographic Survey of 2008 (215), only 28 % of young women and 7 % of young men had tested for HIV. This low uptake of an HIV test was attributed to discrimination which may occur should the results confirm HIV positive. . In the same study approximately 41 % of young women aged 15 to 19 express positive attitudes towards people living with HIV (Swaziland Central Statistical Office and Macro International Inc. 2008: 221). Reluctance of testing among young people may be caused by a negative reaction projected by health care providers toward people living with HIV (IPPF, 2009: 30). The following additional factors drive HIV among young girls or/and risky behaviours in Swaziland:

### **2.8.1. Sexual Behavioral drivers**

Regardless of gender or age population, the basic behavioral drivers of HIV infections in Swaziland are regular partner change, multiple concurrent sexual partners, sexual mixing partners and inconsistent use of condoms (Whiteside, 2005). However studies in recent years have shown that cross generational sex (girls having sexual relationships with men five or more years older than themselves) are at increased risk of HIV infection in Swaziland and in other sub-Saharan countries that are crippled with HIV pandemic (Delva, 2010). Rudolf in Dlamini (2007: 34) states that young women are often involved in cross generational sex for social financial gains and self-esteem (Dlamini, 2007: 34).

### **2.8.2. Cultural and Socio economic drivers**

On the socio-economic front, rampant poverty and high income inequality levels in the country (OpenSpace, 2007: 18) expose poor people to engage in sex for financial and material benefits and for survival (Whiteside , Hickey, Ngcobo ,Tomlinson, 2004:29). In addition, Swaziland is a renowned cultural country in Africa, although some cultural rites constitute the “pride” of Swaziland, others such as polygamy (having more than one wife) and the low status of women in general contribute to the high spread of HIV (Whiteside, 2005:19-21). Polygamy is highly encouraged in Swaziland as it viewed as completing the manhood of men (Masuku, 2007: 57). Studies tell that notions of manhood in the southern African region are closely tied to a man’s ability to attract and maintain several sexual partners (Madlala, 2010: 4), girls as young as 16 have been taken away from their home to be married off to the king (Masuku, 2007: 55).

Although Swaziland has ratified some international conventions that are against women discrimination such as the “convention on elimination of all forms of discrimination against women” (IPPF, 2009: 19), in practice women are still viewed as perpetual minors under the guardianship of their husbands, fathers, brothers or uncles (Aphane, 2007: 47- 48). According to the Swaziland former director of the National Emergency Response Council and AIDS (NERCHA) in Dlamini (2007:33), the high level of poverty and unemployment rated respectively at 70 % and 60 %, often force women to accept anything resulting to

them having limited power in making independent choices such as negotiating sex. Unemployed, uneducated women, women living in rural areas and women aged 15 to 19 are more likely to fail to negotiate safer sexual practices with their husbands, boyfriends or partners; hence they are vulnerable to HIV (Swaziland Central Statistical Office and Macro International Inc., 2008: 253).

## **2.9. CONDOM: USE AND KNOWLEDGE**

Condom use is the main preventive strategy that protects sexually active young people from having HIV. Condoms were shown to be over 90% effective in preventing pregnancy, the transmission of HIV and other sexually transmitted diseases (Stammers 2005:273).

### **2.9.1. The global situation**

According to UNAIDS in Kabikira (2010: 25), knowledge of the effectiveness of condoms in preventing HIV transmission is high in most countries; however many people and particularly high risk population group like young people still fail to use them consistently. A survey commissioned by the United Nations General Assembly in 2007, conducted in 64 countries, found high levels of knowledge related to condoms on average. However on a differential analysis the level of knowledge among females was lower at 55% compared with their male counterparts which was at 70% (UNAIDS 2008:98).

### **2.9.2. Knowledge and condoms use in sub Saharan Africa**

The knowledge on HIV prevention including knowledge on male condoms is increasing among the youth in the Sub-Saharan region (UNICEF, 2013:1). In Rwanda, for example according to UNICEF, “the proportion of young women with comprehensive knowledge of HIV prevention rose from 23 percent in 2000 to 51 percent in 2009”. However despite this improvement, in 2010, these levels were still far below the 2010 target of 95 percent comprehensive HIV preventive knowledge set at the United Nations General Assembly Special Session on HIV/AIDS in 2001 (Tulane University School of Public Health, 2013: 1). In a study of consistent and correct condom use among adolescents done by Bankole et al



(2007: 209-210) in four African countries (Malawi, Ghana, Burkina Faso and Uganda), it was found that only 50 % or less respondents gave correct responses to questionnaire items. The questions related to test respondents' knowledge on how condoms should be worn, when they should be put on in relation to the sexual act and whether they could be used again. In another study in Somalia, levels of knowledge related to condoms were quite low with only 4% of women in the ages 15-24 who knew the effectiveness of condoms in preventing HIV (UNAIDS 2008:98). The level of knowledge a person has about HIV/AIDS, area in which young people live (rural or urban), level of education is associated with use of condom (UNAIDS, 2008: 98-99). Besides, living in an urban area and having low education may be associated with decreased level of condom use in Africa (Zellner 2003:42).

### **2.9.3. Myths in some Sub Saharan African countries**

In Africa in general, knowledge about HIV/AIDS is infested by several social myths that make people including young people to make use of the preventive strategies available to them. Here are some of the HIV myths in some African countries.

Weiss in his study in 2003 (2003: 13) found that it was widely believed by men in the southern African countries that having sex with virgin girls can cure one of the HIV-virus. In another study done by Mufune (2005: 679) on myths about condoms and HIV in Namibia, it was found that although there was a high awareness about the existence of HIV/AIDS, there were misconceptions among respondents that decrease the effectiveness of the preventive strategies implemented. These misconceptions included: HIV can be acquired by sharing of cups; sex with a child or a virgin will cure one of the HIV infection; AIDS results from witchcraft; it is useless to practice protected sex any longer if one is already infected by the HI-virus; AIDS is a punishment from God and only prayer can heal or prevent it; some people intentionally spread AIDS so that they won't die alone. Some of these myths have jeopardised the acceptance of condoms especially by males.

#### **2.9.4. Knowledge, attitudes and utilization of condoms in Swaziland**

The Swaziland Demographic and Health Survey found that more than 80 % of young women and men aged 15 to 19 years old know about male condoms and sources of condoms while approximately 51 % use condoms at first sex. Swaziland Sexual and Reproductive Health services are equally opened to married and unmarried girls as well as young women (The Second National Multi-sectoral HIV and AIDS Strategic Plan 2008: 55), however, the majority of young girls shy away from these services for fear of being harboured prejudice about their sexual and reproductive issues from service providers who are much older than the adolescents, this behaviour, therefore reduces adolescents' access to condom (IPPF, 2009). The Lusweti's study (2009: 10) found that condom use has not improved over the years; for example condom use at last sexual intercourse is still lower than consistent condom use ,but more young people report that they will not have sex with their partner if they believe that the partner is unfaithful and refuses to use a condom. In addition, Ziyane and Ehlers (2006) found in their study that adolescent Swazi boys and girls have difficulty in accessing contraceptives as they have "reservations about using modern contraceptives", they prefer traditional contraception because they believe it has less harmful side-effect and is culturally acceptable.

According to the TRA, young people' positive attitudes towards HIV/AIDS preventive strategies may reduce HIV/AIDS infection among adolescents through adoption of healthy sexual behaviors (Greene, Hale and Rubin, 1997:4). One of the main elements that shape the knowledge and attitudes of young people towards HIV preventive strategies is education (Canadian Ministry of education, 2003: 3).

### **2.10. OVERVIEW OF ADOLESCENCE HIV PREVENTION**

#### **2.10.1. Abstinence and comprehensive sexual education**

From the statistics mentioned above, it is clear that HIV/AIDS is one of the gravest health problems for young people in the world and in Swaziland in particular (Advocates for youth, 2011: 1). Parents, policy makers, teachers, religious entities, in response to this problem, have become more and more interested on the means and approaches that can be used to

reduce HIV/AIDS infection (Boonstra, 2011: 1). Sexual education to young people has been evidenced as having the potential to help to delay early sexual activities but also help young people to have a healthy sexual life (UNAIDS, 2008: 1).

There are a wide range of curriculum-based interventions for sexual education in the last decades both for in and out of school (Lindberg, Santelli, Singh, 2006: 1). These curriculums focused mostly on human anatomy and development and the medical side of sex and reproduction health (Boonstra, 2011: 3). Boonstra (2011: 3) further indicates that current educational programs have evolved considerably and the two main approaches of sexual education that have emerged are: The abstinence-only approach and the comprehensive approach. The abstinence-only approach focuses primarily, on promoting abstinence outside of marriage, moral and public health grounds (Advocate for youth, 2013: 1). The comprehensive approach, on the other hand, supports young people's ability to decide whether and when to have sex (Boonstra, 2011: 3), but also recognizes that sexual debut in adolescence is normative behavior and thus seeks to prepare youth with the knowledge and life skills they need for their development as human beings and for a healthy sexual life (UNICEF, 2011: 1).

Although religious denominations and other related entities support the abstinence-only approach and denounce the comprehensive approach as promoting liberal sexual mores (Shea & Braden 2012:31), several studies have shown that abstinence-only approach is ineffective and actually increases the exposition of young people to HIV/AIDS as they have little knowledge pertaining to healthy sexual life (Dreweke, Wind, 2007:1). It has been recognized that countries that have a more open and positive attitude towards sexuality like western European countries, have better sexual health outcomes compared to the other regions (Boonstra, 2011: 4).

However the implementation of comprehensive sexual education is not an easy one. Each country and region is different, and there is wide variation in policies, government structures, traditions, culture, resources and limitations that implementers have to take into consideration (UNICEF, 2011: 10). UNESCO states that Sexual education programs that are effective at either delaying or reducing sexual activity or increasing condom or

contraceptive use of adolescents are in part determined by their knowledge, attitude and behaviour towards sexuality, sexual diseases and unwanted pregnancies (UNESCO, 2009: 16). This should however be done within the relevant cultural environment (Shea & Braden 2012:30). Boonstra (2011: 5) adds that one starting point for building and sustaining more widespread support for comprehensive sexuality education is to sensitize and mobilize the public for an evidenced comprehensive sexual education through edias and community meetings.

### **2.10.2. A focus on gender inequalities**

Despite this alarming trend, girls and young women in general terms know less than men about how HIV is transmitted and how it can be prevented (UNICEF, 2013: 1). National HIV/AIDS programs, laws and policies as well as NGO's programs should seriously take into consideration the gender dimension in preventing HIV/AIDS (IPPF, 2009: 45). WHO (2013: 1) states that Programs may promote economic opportunities for women, address harmful gender norms and stereotypes, improve access for women trough introducing gender and youth friendly services and address violence against women.

Documentation on gender discrimination and the extent of the problem should be done (IPPF, 2009: 23). Laws that promote women's human rights and gender equality should be written and implemented (UNFPA, 2013: 1). In addition women and young girls empowerment should be effected through education at school level and also at community level (UNFPA, 2013: 1).

## **2.11. ADOLESCENCE'S HIV PREVENTION IN SWAZILAND**

### **2.11.1. Overview history of HIV prevention in Swaziland**

In Swaziland, the HIV prevention started with a slow response in the early eighties when the first HIV case was found (MOHSW, 2006: 2). Rudolph in (Dlamini, 2007: 34) mentions that at that time HIV was generally associated with gay people since its first case was found among homosexual people in United States. HIV was then seen in Swaziland as a foreign health problem as gay lifestyle was perceived as uncommon (Ndlangamandla, 2007: 79);

this slow response resulted to a silent spread of HIV infection from core groups to the general population (Dlamini, 2007: 31). The response only gained momentum following a declaration by King Mswati III during the opening of parliament in 1999 which declared the pandemic as “a national disaster” (IRIN, 2008).

The nature and scope of the response to HIV in Swaziland have grown from being primarily prevention- based and health sector driven in the early years of the pandemic to being comprehensive and multisector-based in later years (Ndlangamandla, 2007: 79-83). The visibility of the impact of HIV/AIDS on people’s lives generate willingness of Swaziland government to provide with a focus on youth, universal access to HIV prevention through its laws, programs and policies such as national multisectoral policies, the integration of HIV/AIDS education and related prospects, (NERCHA, MOHSW, 2009: VIII).

#### **2.11.2. Focus on the youth**

Together with organisations such as the School Health Education programme (SHAPE), the Family Life Association (FLAS) and other stakeholders, the Swaziland National Youth Council (SNYC) programs are founded on the ‘youth menu’, a national response to HIV/AIDS targeting the youth with a focus on life skills change in the knowledge, attitudes, beliefs and behaviour change (Swaziland National Emergency Response Council on HIV/AIDS (2005: 34). The messages focus mostly on Abstinence, delay of sexual debut, consistent use of condoms and more recently on male circumcision (NERCHA, MOHSW, 2009: VIII). The Swaziland Central Statistical Office and Macro International (2008:183) indicate that basic knowledge about STI and HIV/AIDS include: awareness of HIV/AIDS and STI, modes of transmission and mode of prevention, types and signs of STI. Information or knowledge, practices and utilization of family planning services is crucial to help adolescents avoid HIV infection and also unwanted pregnancies and STI (IPPF, 2009: 4).

Although all government HIV prevention and, according to FLAS’ acting Director in IPPF (2009: 37), laws targeting HIV prevention among girls and young women are still not available while this population group is still faced with increased vulnerability.

### **2.11.3. Social Dimension in HIV prevention**

Other aspects such as the social, cultural, economic and political prospects should also be taken into consideration when dealing with HIV prevention especially among young girls to further influence them in adopting positive attitudes towards contraceptives and healthy sexual behaviours (IPPF, 2009: 6-8). From that knowledge, the government of Swaziland has put in place food security programs and other social programs such as scholarships for young people in general to mitigate the impact but also to limit further infection (The Second National Multi-sectoral HIV and AIDS Strategic Plan 2008: 45). Moreover a number of studies have been conducted on gender and child abuse resulting in the review process of Marriage Act of 1920 Girls and Women Protection Act (UNAIDS, 2006: 34).

Although Swaziland's policies and laws related to HIV prevention are relatively in line with the evidenced international standard that is required, their implementation is however problematic (NERCHA, MOHSW, 2009: VIII). Misconceptions, myths, cultural background and religious morals have been a serious obstacle in the effectiveness of HIV/AIDS prevention in Swaziland (Boonstra, 2011: 2). In a research done in 2007 by IPPF (2007: 44), peer educators stated that Sex education for young people is very shallow; they are not exposed to comprehensive sex education resulting in them having problems when they have to take decisions pertaining to sex.

### **2.12. SEX EDUCATION AT SAINT THERESA HIGH SCHOOL**

Very little, if not any documentation exists about the HIV education at Saint Theresa. Information was acquired mostly through interviews with Saint Theresa Management.

Although the Second National strategy (2008) on HIV states that all schools including Christian schools should have career guidance teachers who provide lessons on HIV/AIDS, sexual abuse, drugs and substance abuse, etc. this is not done in many public and mission schools including Saint Theresa (St Theresa's Principal, 10 July, 2013). Sexual reproductive health education received in schools is related only to biology and the discretion is left to the individual teachers who, in most of the cases, are not keen to discuss sex education among young children, because of its sensitivity in the socio-cultural context of the Catholic

Church; and for teachers who attempt to teach the subject, the emphasis is on abstinence until marriage. In addition there are regular workshops or talks conducted by local and foreign priests focussing mostly on abstinence only sex education (Euteneur, 2009).

### **2.13. KNOWLEDGE, ATTITUDES OF ADOLESCENTS AND RISK BEHAVIORS IN RELATION WITH HIV/AIDS AND CONDOMS USE IN CATHOLIC HIGH SCHOOLS IN AFRICA AND IN SWAZILAND**

The potential for Faith-based organizations (including Catholic Church) to be important role-players in HIV prevention is undermined by the church's difficulties with discussing sexuality, avoiding stigma, gender issues and acceptance of condoms (Mash and Mash, 2013:1). In the same study done by Mash and Mash (2013: 2-6) on faith based organization and HIV prevention in Africa, it was found that in contrast with high-income countries, religiosity does not have an overall positive impact on risky sexual behavior in Africa although Churches may have a positive impact on alcohol use and its associated risky behavior, as well as self-efficacy. It was also found in the same study and in a study done in Zomba (Malawi) on HIV attitudes and knowledge of catholic high school students, that the influence of the church on sexual behavior may also be associated with the degree of social engagement and control within the church culture (Mwale, 2008: 288–299). In another study done by the Catholic Organization for Relief and Development AID (2008: 52) on adolescent's reproductive health in catholic high school in Congo, it was found that adolescents had inadequate knowledge on Family planning, STIs including HIV/AIDS and Abortion.

There is no documentation so far on HIV attitudes and knowledge of Catholic high school learners. However in a study done by Simelane (2005: 30) in a Nazarene training school it was found that there were gaps, doubts or lack of confidence in the knowledge of HIV/AIDS of the students. In the same study, students' attitudes were fatalistic and in denial of the risk of infection, with negative attitudes displayed towards people living with AIDS fear in communicating HIV issues, inconsistency of condom use like other young people and negative attitudes towards condom use possibly due to religious orientation (Simelane 2005: 100). In addition the study found that all learners had a very low self-esteem leading to

uncertainty on their perceived risk of contracting the virus besides, though most had adopted abstinence and monogamous relationships, there were pockets of high-risk sexual behaviours displayed by a minority.

Given that there is no documentation on HIV/AIDS's attitudes and knowledge of Catholic high school learners in Swaziland, the study may provide evidence based information that may give parents, teachers, Catholic organisations and even other faith based organisations and the government to better tackle the factors that increase HIV spread among young people.

#### **2.14. CONCLUSION**

Efforts have been certainly done at the government levels in reducing the HIV spread among young people in Swaziland through creation of national institutions, policies and laws aiming either directly or indirectly at decreasing youth's HIV infection; however efforts still need to be done in sensitizing people about the evidenced best approach to sexual education. More documentation on potential issues linked to HIV infection should also be done so that proper strategies to bring the public to support a proper sex education can be developed and implemented. Proper strategies are crucial in this strong religious and cultural context of Swaziland.



## **CHAPTER 3:**

### **RESEARCH DESIGN AND METHOD**

#### **3.1. INTRODUCTION**

A research's validity is very much influenced by the use of the research approach used and most importantly the application of the characteristics of the specific design and methodology. This section presents the study design, methodology and the level of internal and external validity of the study.

#### **3.2. RESEARCH DESIGN**

This research is a quantitative, descriptive correlational research (cross sectional and prospective) seeking to describe the knowledge, attitudes and risk behaviors of adolescents girls aged 12 to 19 years from Form I to Form IV in relation with HIV/AIDS and condoms utilization in catholic girls schools of Manzini, Swaziland.

#### **3.3. RESEARCH METHOD**

##### **3.3.1. Sampling**

The stratified random sampling was used to divide the population which was 423 students into two stratum of approximately comparable age within the stratum and more than two years difference in average age from one stratum to the other: the first stratum consisted of 181 students from form I to Form II and the second stratum with 242 students from Form III to Form V. Then the calculated sample size corresponding to each stratum was then simply and randomly chosen from the list of the students of each stratum. Only registered students aged 12 to 19 years from grade I to grade V of Saint Theresa Catholic high school were allowed to participate to the study. Students aged less than 12 years and more than 19 years were excluded. In addition students who attended classes but were still not registered were excluded.

### **3.3.1.1. Population**

The target population for this study was the students registered in 2013 at St Theresa, the only catholic school for females, of Manzini city (Swaziland), from Form I to Form V aged from 12 years to 19 years.

### **3.3.1.2. Ethical issues related to sampling**

Sample size was calculated according to quantitative approach. Each student had the chance to be selected. In addition, the criteria of inclusion and exclusion mainly based here on age and class room was well respected.

### **3.3.1.3. Sample**

The sample included 261 students, of whom 149 were from Form I to II (Stratum 1) and 112 were from Form III to V (Stratum 2). The following parameters were used to calculate the sample size:

$N = 423$ : Total population.

$N_1 = 181$ : Population in stratum 1 (Form I + Form II).

$N_2 = 242$ : Population in stratum 2 (Form III + Form IV + Form V).

$S_1$ : sample in stratum 1

$S_2$ : sample in stratum 2

The following parameters were also taken into consideration:

$D = 5\%$ : maximum allowable difference (given that we will expect more proportions to be in the range of 20% to 80%).

$P = 0.5$ : estimated proportion (we will use 0.5 because the population size is small, it will practically be possible to work with the largest possible sample size)

$C = 0.95$ : Confidence level (95% confidence level).

$Z = 1.960$  (area under the normal curve corresponding to 95% confidence level)

Based on these parameters, sample size was calculated as follow:

$$S2 = n / 1 + (n/N2) \text{ in which } n = Z \times Z [ P(1-P) / (D \times D) ]$$

$$n = 1.960 \times 1.960 [0.5(1-0.5) / (0.05 \times 0.05)] = 384.16$$

$$S2 = 384.16 / 1 + (384.16/242) = 148.47 \text{ (approximately 149) which correspond to 62\%}$$

$$S1 = 62\% \times N1 = 62\% \times 181 = 112.22 \text{ (approximately 112)}$$

$$\textbf{Total Sample size = } S1 + S2 = 149 + 112 = 261 \textbf{ students}$$

### 3.3.2. Data collection approach and method

This study used a structured and scientific data collection approach that is usually appropriate for quantitative research. The group administered questionnaires method was employed as students filled the questionnaires on their own within a group, which was constituted with students of a specific form (grade). The data collection took place in Saint Theresa's premises. Students filled questionnaires in their respective classrooms.

#### 3.3.2.1. Development and testing of the data collection instrument

The questionnaire was used to collect data in this study. According to Burns and Grove (2009: 406), a questionnaire is "a printed self-report form designed to elicit information that can be obtained from a subject's written responses. Questionnaires should focus on the essential parts of the topic to be covered by the study and to increase credibility of the questionnaires, researchers are often encouraged to employ Questionnaire used in similar studies and adapt it to the specific study (Burns and Grove, 2009: 406), In this study, the supervisor, Dr Ziyane proposed to the researcher a questionnaire she developed in 2011. The questionnaire was modified to address the current topic; it was divided into 4 sections the demographic and socio economic section, the sexual behaviour and attitudes section, the HIV/AIDS attitudes, knowledge and behaviour section and attitudes, knowledge and use of condoms and it was composed of 46 questions: 45 multiple questions and 1 open ended question. In line with the TRA, only the attitudes and knowledge components were used. The questionnaire was also computer printed using "Arial" style with font size "12" for clarity

and legibility. The questionnaire was simple and understandable at the level of high school students, it was also standardized, and anonymous increasing in that way its reliability. Burns and Grove (2009: 406) discourage the use of open ended questions in a questionnaire because they are often difficult to interpret. In the questionnaire only one question on providing at least 3 HIV preventive strategies, was open ended, The Supervisor Dr. Ziyane and UNISA Higher Degrees Committee of the Department of the College of Human Sciences checked the questionnaire for completeness, legibility and clarity of multiple choice responses.

In addition, the questionnaire was compared to other questionnaires used in the country surveys like the Swaziland demographic and health survey and the contents were found to be similar, to a big extent. The research also collaborated with the statistician to further clarify the questionnaire for an efficient analysis.

To pre-test the instrument, the researcher administered the questionnaire on 25 students of Manzini Nazarene High School because Nazarene high schools are also Christian schools like Catholic schools and they are commonly viewed in terms of their characteristics here in Swaziland like Catholic schools. The pre-test group was composed 25 students randomly chosen from Form I to Form II, aged 13 to 19 years old.

The principal told the researcher that it was unnecessary to inform the parents since in his opinion there was no really sensitive question in the questionnaire. He said he will present himself as a guardian to the students and just inform verbally the parents about the research.

Before completing the questionnaire, the researcher explained to the students the overview of the study and their right to decide not to participate to the pretest study even if they have been asked by the principal to do so. Each category or question was also explained clearly to the group. The students in the pretest took approximately 30 minutes to complete the paper. During the completion of the questionnaire, the students expressed their confusion whether to tick more than one item when there are multiples responses to choose for a question and the response from the researcher was yes where appropriate. There was an

error on question 30 item, “if your response to question 33...” 33 were supposed to be replaced by 29. It was also seen that it was unnecessary to write the name of the school in part 1 of Section 1 because we were dealing only with one school. In addition, given that only girls were the participants of this study, the word “girlfriend” on item 2 of question 14 was cancelled. Most of students did not also specify when ticking “others” item, this was added at the “teacher statement form” to remind them to encourage students to specify.

### **3.3.3. Validity of the instrument**

According to Delport (2005:160) validity of a measuring instrument is established when the instrument actually measures the concept in question and the concept is measured accurately. While Babbie (2007:146) describe validity as the extent to which an instrument measures what it purports to measure. As described above in section 3.3.2.1., the questionnaire was developed in collaboration with the supervisor, the statistician and using the literature review in order to ensure high reliability. A teacher statement form (Appendix E) was developed and used by teachers whereby they were requested to explain each category or question clearly to respondents. This is so because the validity of a survey relies heavily on the respondents’ willingness and ability to report their perceptions accurately (Stommel & Wills 2004:158).

### **3.3.4. Internal and External validity of the study**

Given that internal validity deals with the extent to which causal-effect can be drawn, mostly important in hypothesis-testing research design, more so in true experimental research (Terre Blanche et al. 2006:90); the external validity was the focus here. Bowling (2009:202) has associated inadequate sampling technique with bias and poor external validity of the study. The probability sampling was used to ensure representativeness of the target population. The data collection took place at the school’s premises where students could feel comfortable. However as an instruction by the school’s management, the data collection was done by the teachers, this could create information bias during data collection as they could have influenced the participants’ answers.

### 3.3.5. Data collection Process

Following a verbal approval to do the research from the Principal in 2012 and a written approval at the end of July 2013 as a response to the research's permission letter **(Appendix A)**, Saint Theresa vice principal received information packets which included a letter to parents by the principal **(Appendix B)** and a number of parent/Guardian and student informed consent forms **(Appendix C)**. In Appendix C, the overview of the study as well as the risk of the study were clearly stated so that parents/guardians and students can take an informed decision. A copy of the self-administered questionnaire **(Appendix D)** was left to the vice-principal for parents wishing to see the survey prior to making consent decisions.

All class teachers were given one informed consent form just to have an overview of the study. A meeting with the vice principal and the teachers was held to discuss about the study and means to distribute the questionnaires. The Vice-principal did not require the researcher to attend the meeting because of some internal circumstances. These teachers also received the teacher statement form **(Appendix E)** to use when distributing questionnaires. Students had a period of 3 days to return a signed permission form in order to be eligible for survey participation. Each student from each stratum was attributed a number and these numbers were written on each parent/student consent form. All students numbers included in the sample were written to each questionnaire.

At the designated day and time of survey administration, the questionnaires were distributed by the class teachers as requested by the school's management during the period of 5<sup>th</sup> August to 16<sup>th</sup> August 2013. Only the attributed students sampling numbers were retained for the study given that all students and parents/guardians agree to participate to the study. Other students not participating to the study were kindly explained about the logic behind sampling and sent to the library. Teachers were asked by the researcher and were expected to read the teacher statement form before distributing the questionnaires and they were also supposed to allow students to ask questions before distribution of the questionnaires. The form allowed teachers to present again the over view of the study and further instructions

related to the anonymity, confidentiality and other issues pertaining to the validity of the collection instrument.

### **3.3.6. Data Cleaning**

In order to ensure that no mistake occurred during data entry process to EPI info, the data was double checked both by the researcher and the statistician. Some frequencies analysis were run by the statician to identify potential discrepancies in the data collected. Summaries and percentages were also double-checked

### **3.3.7. Ethical considerations**

Ethical issues need particular care when conducting a research about adolescents on sensitive issues; these include the respect of confidentiality, respect of people's rights to refuse participation, maintenance of privacy during discussion and non-disclosure of information to other family members or people outside the group (Babbie, 2004). Informed consent means that participants have adequate information about the research, are capable of comprehending the information and have the power of free choice enabling them to voluntary consent to participate in the study or not (Babbie, 2004: 61-65).

#### **3.3.7.1. Voluntary participation**

The students/participants and their guardians were required to give a written consent to participate in the study. The letter of consents contained the purpose, the methodology, the anticipated risks, the benefits, the terms of participation and other relevant details would be explained so they could take an informed decision regarding the participation of their child to the study.

#### **3.3.7.2. No harm to the participants**

Potential risks of the survey were explained to participants. Potential risks included possible stress due to answering questions and thinking about experiences or decisions of the participant. Participants were assured that they could discontinue their participation to the

study and exercise their right to participate, should they feel otherwise. They may not respond to a question that they feel it is unfair or sensitive to their feelings

Participants can also experience stress from a negative reaction of the findings from the school management specifically in the case there is a high level of participants who are sexually involved. Such issues were discussed with the school's management with an emphasis on how they will use the findings. In case of stressful experiences when filling the questionnaires, participants were informed that they could go to the "health and support centre" organization for free counseling.

#### **3.3.7.3. Anonymity and confidentiality of participants**

Confidentiality was maintained by participants' contact information being protected. Students were not asked to write their names on the questionnaire and questions and statements of the questionnaire were appropriate to the demographical and educational profile of the students using multiple choice questions and simple language. Completed questionnaires were put in envelopes and sealed although not put in a closed box as planned in the research proposal. The school's management team judged that it was not necessary to do so.

#### **3.3.7.4. Integrity of the researcher**

The researcher introduced herself as a researcher/student and clearly presented the purpose of the research to the school Headmaster as stipulated in the research proposal. The researcher with the support of the supervisor Dr. Ziyane, also respected the rigorous methodology of descriptive quantitative research approach chosen by acknowledging to readers the shortcomings of the study and presenting accurate findings. In addition no gift or money was given to respondents in relation with the study.



### **3.3.7.5. Ethical considerations related to data collection**

The pre-test of the questionnaire allowed the researcher to correct and improve the questionnaire structure as well as the data collection process. As explained earlier, the data collection was performed by the class teachers as required by the school. The researcher convened a meeting with the vice principal and class teachers individually whereby the researcher gave instructions on how the questionnaire should be administered. In addition, a “teacher statement form” was handed to teachers, this form contained instructions which explained the confidentiality issues, the purpose of the research, the reason for conducting the research, the significance of the research and the participants’ rights to participate and to discontinue at any stage of the study should there be a need to exercise that right. They were also instructed to ensure that each participant understood and completed each item in the questionnaire.

### **3.3.7.6. Consent and ethical clearance of Institutions**

Ethical clearance for the study was sought from the University of South Africa Research and Ethics committee; the Swaziland Ministry of Health Ethics Committee and approval was received from St Theresa High School.

## **3.4. DATA ANALYSIS**

Most of the variable had categorical data with the exception of age. We recoded age into age groups of three years each. We had only one qualitative question in the questionnaire. The question was recorded during the data entry process to capture the four most appropriate answers any other valid answer was captured as other. The data were captured manually with the assistance of a biostatistician using EPI INFO 7 program. After entering the data, they were checked and cleaned, 2x2 and means analysis were the main analysis performed. Descriptive statistics using tables and graphs were used to summarize data obtained from the study. The fisher exact test was used in one association done in the study on a small subgroup of sexually active respondents; the level of significance used was 5%.

### **3.5. CONCLUSION**

This chapter (chapter 3) provided an overview of the research design; a quantitative descriptive and correlative survey design. Attention was given to: the sampling approach and technique, the data gathering instrument (questionnaire), data analysis, reliability and validity issues; and ethical principles relating to the current research. In the next chapter (Chapter 4) the study results are presented.

## **CHAPTER 4**

### **ANALYSIS, PRESENTATION AND DESCRIPTION**

#### **4.1. INTRODUCTION**

In this chapter, the results of the data analysis are presented. The overall purpose of the study was to describe the knowledge, attitude and risk behavior of adolescents in relation with HIV/AIDS at Saint Theresa Catholic high school in Manzini. The results are presented in line with the specific objectives which were to:

- Assess the knowledge adolescents have regarding HIV prevention strategies,
- Identify sexual behaviors which may increase adolescents' risk of acquiring HIV infection
- Evaluate attitudes of adolescents that may increase their risk of acquiring HIV infection
- Determine factors that may increase adolescents' risk of acquiring HIV infection.

The chapter begins with an overall summative descriptive statistics report on the different sections of the questionnaire namely: demographic and socio economic data, HIV knowledge (transmission, prevention, the most infected population); attitudes towards people living with HIV as studies, HIV testing and attitudes, sexual behaviour and attitudes. Results related to objective 2 are found in chapter 2 of the study; result related to objective 3 are found in chapter 2 and 3 of the study and results related to objective 1 and 4 are found in all the chapters.

#### **4.2. DEMOGRAPHIC AND SOCIO ECONOMIC SECTION**

The respondents of this survey consisted of 268 female students of Saint Theresa high school from Form 1 to Form 5. 8 students' responses were discarded due to the fact that they were above 19 years of age. Table 4.1 shows that 84 students are aged 12 to less than 15 years; 145 students are aged 15 to less than 18 years and 31 students are aged 18 to less than 20 years. Students aged 15 to 17 years were the most represented (55.77%) while

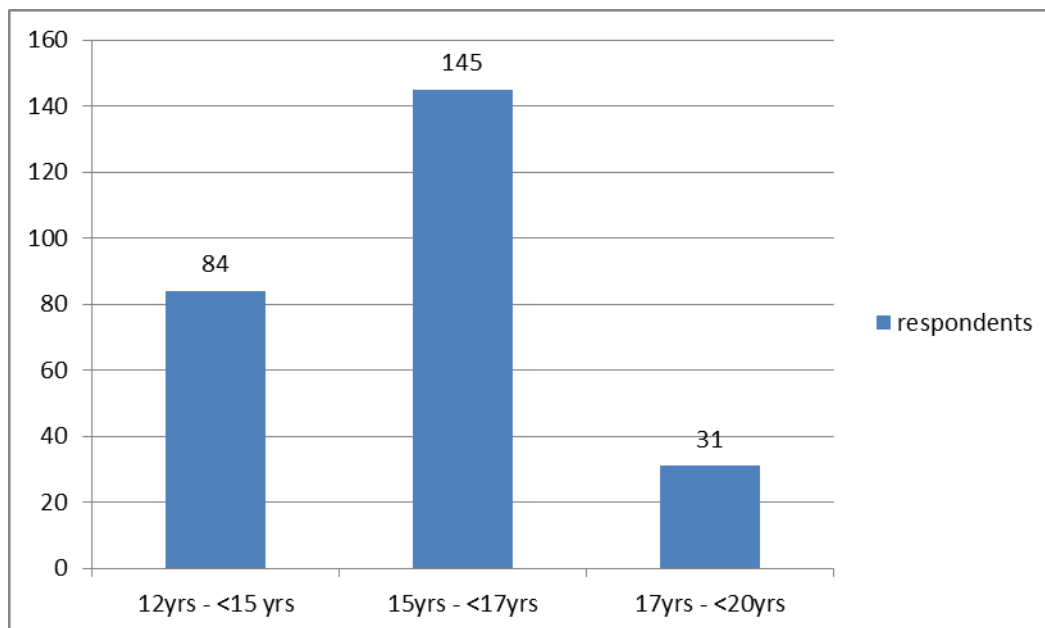
those aged 18 to 19 years were the least represented (11.92%). As shown in table 4.2b the mean age for each level of education was 14 years for Form 1, 15 years for Form 2, 16 years for Form 3, 17 years for Form 4, and 18 years for Form 5.

#### 4.2.1. Age distribution of respondents (n= 260)

1.1 **Table 4.1 Age distribution of respondents in the study (n=260)**

CATEGORY	FREQUENCY (f)	PERCENTAGE
12 < 15	84	32.31%
15 < 17	145	55.77%
18 <20	31	11.92%
<b>TOTAL</b>	<b>260</b>	<b>100.00%</b>

**Figure 4.1 Age groups Distribution**



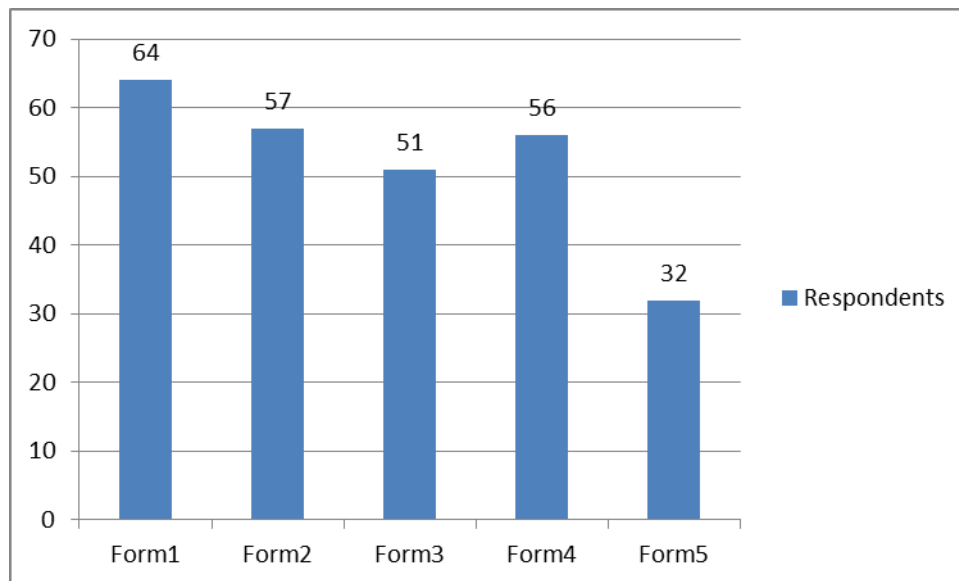
#### 4.2.2. Educational status of respondents (n= 260)

Table 4.2a shows the number of respondents in each educational level. Apart from form 5 where we have the lowest number of respondents 32 (12.31%), the number of respondents in the other level of education are within the same range varying from 51 (19.62%) in Form 3 to 64 (24.62%) in Form 1.

**Table 4.2a: Number of respondents at each educational level**

EDUCATIONAL ATTAINMENT	FREQUENCY (f)	PERCENTAGE
Form 1	64	24.62%
Form 2	57	21.92%
Form 3	51	19.62%
Form 4	56	21.54%
Form 5	32	12.31%
<b>TOTAL</b>	<b>260</b>	<b>100.01%</b>

**Figure 4.2: Number of respondents at each educational level**



#### 4.2.3. Mean age of respondents in each level of education

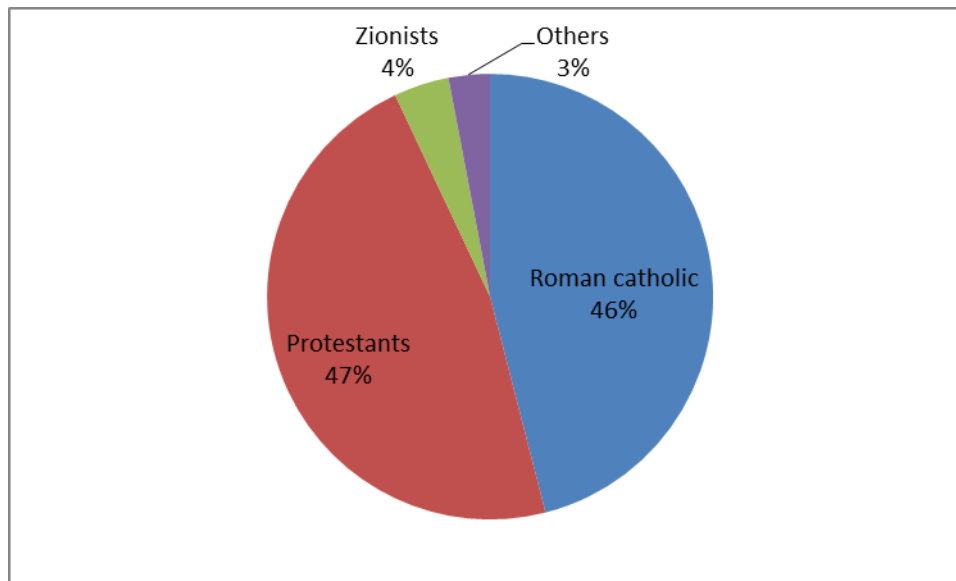
**Table 4.2b: Mean age of respondents in each level of education**

Measures	Mean	Min	Max
<b>Form 1</b>	14 years	12 years	17 years
<b>Form 2</b>	15 years	13 years	17 years
<b>Form 3</b>	16 years	14 years	19 years
<b>Form 4</b>	17 years	15 years	19 years
<b>Form 5</b>	18 years	16 years	19 years

#### 4.2.4. Religious affiliation

Protestants and catholic are almost equally represented with 47% and 46 % respectively. Zionists and other faith based denominations are the least represented with 4% and 3 % respectively.

**Figure 4.3: Religious Status of respondents**



#### 4.2.5. Other socio demographic items (n= 260)

Table 4.3 show that only 87 respondents (33.46 %) live with both their parents while a significant number of respondents 93 (35.77 %) live only with their mother. In addition, most of the respondents' guardians/parents are employed 168 (64.62 %) or self-employed 58 (22.31%). The majority live in urban areas 65.77 %, and in accommodation with more than 2 bedroom 68.08 % with large families of 4 (18.46 %), 5 (28.85 %), 6 and more people (31.92 %).

**Table 4.3: Other socio Demographic components**

Questions items	ANSWERS OPTIONS	FREQUENCY (f)	PERCENTAGE
<b>Living arrangement</b>	Mother	93	35.77%
	Father	22	8.46%
	Both parents	87	33.46%
	Guardian	23	8.85 %
	Grandparents	25	9.62%
	Siblings	8	3.08%
	Stepmother	1	0.38%
	Other	1	0.38%
	<b>Total</b>	<b>260</b>	<b>100.00%</b>
<b>Source of incomes for the person living with you</b>	Paid employment	168	64.62 %
	Self employed	58	22.31 %
	Unemployed	32	12.31 %
	Others	2	0.77 %
	<b>Total</b>	<b>260</b>	<b>100.01%</b>
<b>Type of accommodation</b>	On room	14	5.38 %
	One bedroom flat	10	3.85 %
	2 bedrooms	59	22.69 %
	More than 2 bedrooms	177	68.08 %
	<b>Total</b>	<b>260</b>	<b>100.00%</b>
<b>Number of people living in the house</b>	One	2	0.77 %
	Two	18	6.92 %
	Three	34	13.08 %
	Four	48	18.46 %
	Five	75	28.85 %
	Six or more	83	31.92 %
	<b>Total</b>	<b>260</b>	<b>100.00%</b>
<b>Place of habitation</b>	Urban area	171	65.77 %
	Peri-urban area	47	18.08 %
	Rural area	42	16.15 %
	<b>Total</b>	<b>260</b>	<b>100.00%</b>

### 4.3. KNOWLEDGE ABOUT HIV/AIDS (transmission and prevention)

#### 4.3.1. Knowledge on HIV transmission

Table 4.4 shows that the majority of respondents know that HIV is transmitted through sexual intercourse 242 (93.08%) and from pregnant mother to child 233 (89.62 %). The majority also know that AIDS is not curable 233 (89.62 %), HIV is not spread through sharing of clothes 256 (98.46 %) and HIV is not spread through mosquito 205 (78.85 %). Most of respondents (89 %) are also aware that young people are the most infected by the virus as shown in figure 4.3. Religious affiliation.

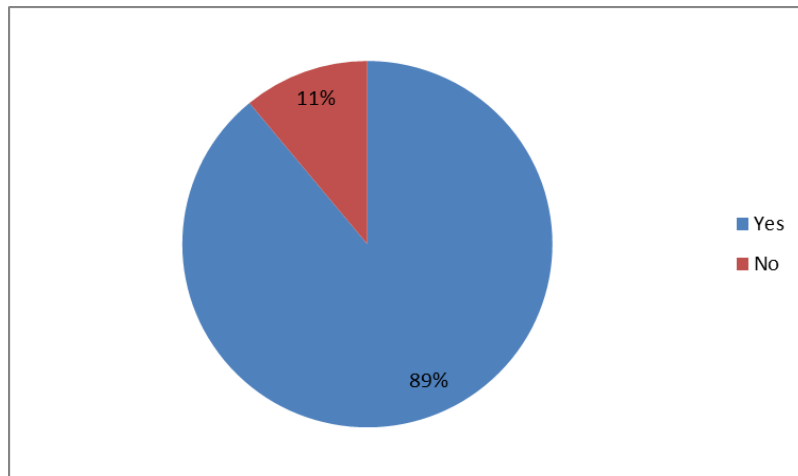
**Table 4.4: Knowledge of respondents on HIV transmission**

QUESTIONS ITEMS	FREQUENCY (f)			PERCENTAGE		
	True	False	Total	True	False	Total
HIV is spread through sexual intercourse	242	18	260	93.08 %	6.92 %	100.00%
HIV spread from pregnant mother to child	233	27	260	89.62 %	10.38 %	100.00%
AIDS is a curable disease, if diagnosed in early stage	27	233	260	10.38 %	89.62 %	100.00%
the HIV spread from sharing of bath room, clothes and kissing	4	256	260	1.54 %	98.46 %	100.00%
HIV spread through mosquito bites	55	205	260	21.15 %	78.85 %	100.00%



#### 4.3.2. Knowledge of respondents on HIV most infected population (n= 260)

**Figure 4.4: Knowledge of youth as the most affected population by HIV**

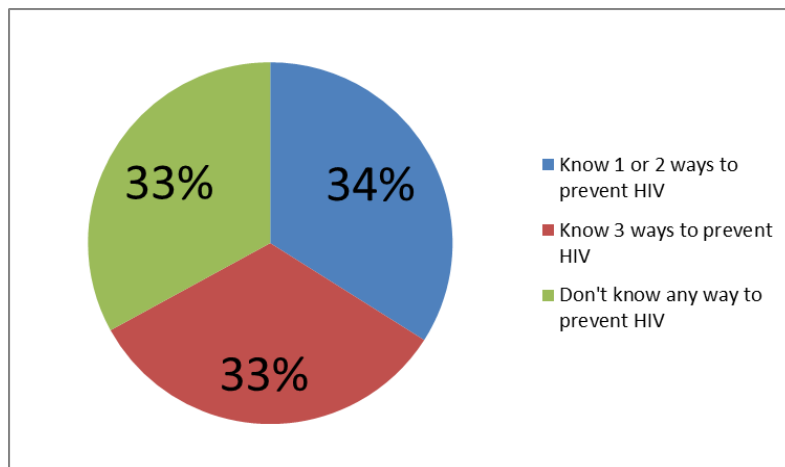


#### 4.3.3. HIV prevention (n= 260)

The HIV prevention aspect here was focused on methods to prevent directly from HIV transmission such as use of condoms and abstinence.

Figure 4.5 below shows that only 34 % of respondents know respectively 1 or 2 ways and 3 ways to protect themselves from HIV infection. An alarming 33 % does not know any way to protect from HIV infection.

**Figure 4.5: Knowledge of HIV prevention by the respondents**



#### 4.4. ATTITUDES TOWARDS PEOPLE LIVING WITH HIV/AIDS (n= 260)

Table 4.5 show that the majority of respondents do not stigmatize people living with HIV/AIDS as 81.54 % do not believe that only people who lead immoral lives get HIV 212 and that AIDS patients pay the price for their immoral life 193 (74.23 %). However there is still a high belief among respondents (74.23 %) that banning prostitution can control the spread of HIV, it is therefore more likely that prostitutes who live with HIV/AIDS may receive harsher attitudes from participants than other people living with HIV/AIDS.

**Table 4.5: Attitudes towards people living with HIV**

QUESTIONS ITEMS	FREQUENCY			PERCENTAGE		
	Yes	No	Total	Yes	No	Total
Only people who lead immoral lives will get HIV	48	212	260	18.46 %	81.54 %	100.00%
AIDS patients pay the price for their immoral life	67	193	260	25.77 %	74.23 %	100.00%
Banning prostitution can control the spread of HIV	193	67	260	74.23 %	25.77 %	100.00%

#### 4.5. HIV TESTING AND ATTITUDES (n= 260)

The table 4.6 below shows that although only 58 (22.31%) of respondents have tested for HIV, the majority 216 (83.08 %) is willing to take an HIV test.

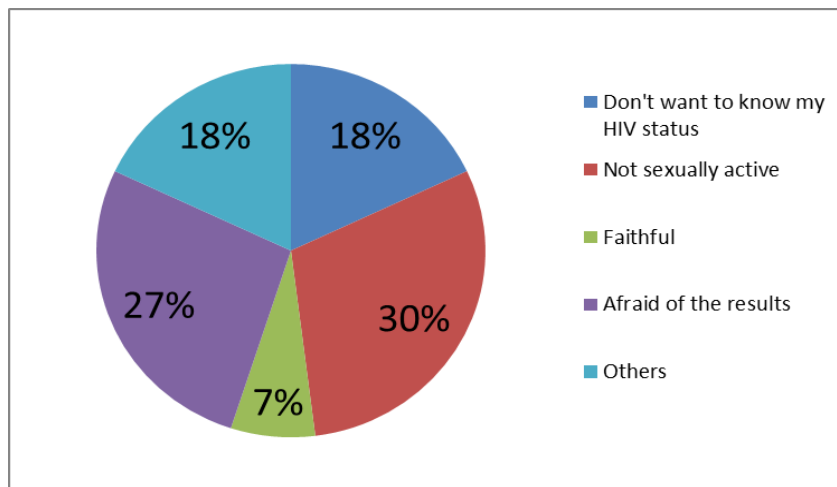
**Table 4.6: Attitudes of respondents towards HIV testing**

QUESTIONS ITEMS	FREQUENCY		Total	PERCENTAGE		Total
	Yes	No		Yes	No	
Have you ever tested for HIV	58	202	260	22.31 %	77.69 %	100.00%
willing to take an HIV test	216	44	260	83.08 %	16.92 %	100.00%

#### 4.5.1. Reasons for not testing for HIV (n= 44)

The figure 4.6 below shows that 30 % of respondents do not do a HIV test because they are not sexually active. A significant 27 % of respondents are afraid of the result and 18 % do not want to know their result while 7 % believe they are faithful to their partners.

**Figure 4.6: Reasons for respondents not willing to get tested for HIV.**



#### 4.5.2. Knowledge of places that provide HIV testing (n= 44)

Table 4.7 show that the Clinic 145 (55.77 %) and the hospital 135 (51.92 %) are the two most known places by respondents for the provision of HIV testing.

**Table 4.7: Knowledge of places that provide HIV testing (the question yielded multiple responses)**

Places that provides HIV testing	Frequency of students	Total of students who responded	Percentage
Hospital	135	260	51.92 %
Clinic	145	260	55.77 %
Health Centre	89	260	34.23 %
VCT Centre	85	260	32.69 %
Others	9	260	3.46 %

#### **4.6. MALE CONDOMS USE: ATTITUDES, KNOWLEDGE AND USE**

##### **4.6.1. Heard of condoms (n= 260)**

Table 4.8 below show that most of the respondents 252(96.92 %) have heard of condom, but few of them 9 (3.46 %) have ever use contraception.

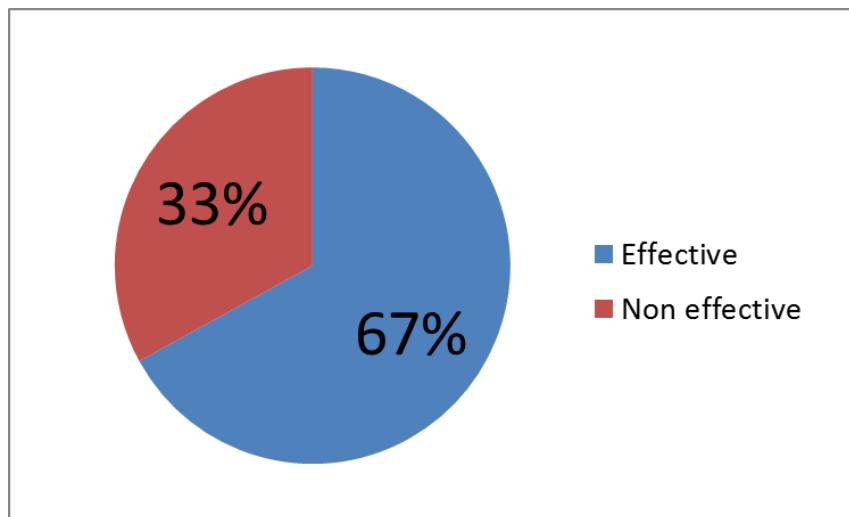
**Table 4.8: Respondents who have heard of male condoms and who ever used contraception**

QUESTION ITEM	RESPONSE OPTIONS	FREQUENCY	PERCENTAGE
<b>Have ever heard of condom?</b>	YES	252	96.92 %
	NO	8	3.08 %
	<b>Total</b>	260	100.00%
<b>EVER USED CONTRACEPTION?</b>	YES	9	3.46 %
	NO	251	96.54 %
	<b>Total</b>	260	100 %

##### **4.6.2. Effectiveness of male condoms in preventing HIV (n= 260)**

Figure 4.7 show that the majority of respondents 67% believe in the effectiveness of male condoms to protect oneself from HIV infection.

**Figure 4.7: Respondent belief about the effectiveness of male condoms**



#### 4.6.3. Risks of sex without male condom use or inconsistent condom use (n= 260)

Table 4.9 show that the vast majority 259 (99.62 %) agree that sex without condoms put a person at risk of STI, HIV and unwanted pregnancy. The same table also show that the majority 242 (93.08 %) agree that condom should be used all the time.

**Table 4.9: Risk of sex without male condoms use or inconsistent condom use**

QUESTION ITEM	RESPONSE OPTIONS	FREQUENCY	PERCENTAGE
Sex without condoms put a person at risk of STI, HIV and unwanted pregnancy	Agree	259	99.62 %
	Disagree	1	0.38 %
Total		260	100.00%
Sex with no condoms once in a while is not a risk of STI, HIV and unwanted pregnancy	Agree	18	6.92 %
	Disagree	242	93.08 %
Total		260	100.00%

#### **4.6.4. OTHER ATTITUDES TOWARDS MALE CONDOM USE (n= 260)**

Table 4.10 show that the majority 153 (58.85%) disagree that condoms reduce pleasure. The same table also show that there are more respondents 91(35.00%) who agree that it is embarrassing to ask or buy condom than those who disagree 81 (31.15%) or who don't know 88(33.85%). Table 4.10a also show that 243 (93.46 %) of respondents agree that use of condoms is a sign of respect. 189 (72.69%) respondents don't have a boyfriend and most of the respondents (58.46%) said that if they have a boyfriend, they won't feel confident to get them to use a condom.

**Table 4.10a: Others attitudes towards male condoms use**

QUESTION ITEM	RESPONSE OPTIONS	FREQUENCY	PERCENTAGE
<b>Condoms reduce pleasure</b>	Agree	36	13.85%
	Disagree	153	58.85%
	Other (not sure)	71	27.30%
	Total	260	100.00%
<b>It is embarrassing to ask/buy condoms</b>	Agree	91	35.00%
	Disagree	81	31.15%
	Don't know	88	33.85%
	Total	260	100.00%
<b>condoms use: sign of respect, caring and responsibility</b>	Agree	243	93.46 %
	Disagree	17	6.54 %
	Total	260	100.00%
<b>Do you have a boyfriend</b>	Have boyfriend	71	27.31%
	Don't have boyfriend	189	72.69%
	Total	260	100.00%
<b>Level of confidence in getting a boyfriend to wear a condom.</b>	Very confident	33	12.69%
	Somewhat confident	33	12.69%
	Not confident at all	152	58.46%
	Others (not sure)	42	16.16%
	Total	260	100.00%

Table 4.10b show that among those who have boyfriends 71, the majority 38 (53.52%) talk about condoms or discuss about condoms use with their boyfriends; the same percentage of respondents feel comfortable discussing condom use with boyfriend. 25.35 % of respondent believe their boyfriend will not trust them if they bring up the subject of condom

and 33.80 % believe their boyfriend will think they have other boyfriends and 40.85% believe that their boyfriend will be fine with it.

**Table 4.10b Table assessing attitudes about condom use among respondents who have boyfriends (n=71)**

QUESTION ITEM	RESPONSE OPTIONS	FREQUENCY	PERCENTAGE
Talk about condoms with boyfriends	Yes	38	53.52%
	No	33	46.48%
	Total	71	100%
Comfort in discussing condoms use with boyfriend	Yes	38	53.52%
	No	33	46.48%
	Total	71	100%
Reaction of boyfriend if “bring up” the subject of condoms	He will not trust you	18	25.35%
	He will think that you have other boyfriends	24	33.80%
	Others (he is fine with it)	29	40.85%
	Total	71	100.00 %

#### **4.7. HIV RISKY BEHAVIOURS, SEXUAL BEHAVIOUR AND ATTITUDES (n= 260)**

##### **4.7.1. Risky sexual Behavior and attitudes**

Table 4.11 shows that only 16 respondents (6.15 %) had ever had sex and of those 16 sexually active respondents 5 (31.25 %) had forced sex (rape), 11 (68.75 %) had voluntary sex, the same number used condoms and 11 (68.75) had sex with their boyfriends. 3 (18.75 %) respondents had forced sex with their relatives. 10 (62.50 %) out of the 16 used condom during their last sexual intercourse. 5 (1.92 %) respondents out of the 16 had sex for gain.



The majority of all respondents 216 (83.08 %) think that it makes a difference in their sexual life if sex is delayed and 254 (97.69 %) believe that it is not ok to have sex once you have a boyfriend.

In addition the majority (83 %) of all respondents (N= 260) believe that it makes a difference to delay sex compared to those who are sexually active at an early age and 98 % of respondents believe it is not ok to have sex once you have a boyfriend.

**Table 4.11: assessment of risky sexual Behavior and attitudes of respondents**

<b>QUESTION ITEM</b>	<b>RESPONSE OPTIONS</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
<b>Have you ever had sex</b>	Yes	16	6.15 %
	No	244	93.85 %
	Total	260	100%
<b>How did the first sexual intercourse occurred</b>	<b>Desire to have sex</b>	9	56.25 %
	<b>Forced/raped</b>	5	31.25 %
	Other	2	12.50 %
	<b>Total</b>	16	100.00 %
<b>Ever use a condom if sexually active?</b>	Yes	11	68.75%
	No	5	31.25%
	Total	16	100%
<b>Type of sexual partners</b>	Boyfriend	11	68.75 %
	Simple friend	2	12.50 %
	Relative	3	18.75 %
	Total	16	100%
<b>Used condoms at last sex</b>	Yes	10	62.50 %
	No	6	37.50 %
	Total	16	100%
<b>Ever engaged in sex for gain?</b>	Yes	5	1.92 %
	No	255	98.08 %
	Total	260	100%
<b>Any difference in sexual health to delay sex compared to those who have early sexual life?</b>	Yes	216	93.91 %
	No	14	2.17 %
	Total	230	100%
<b>Do you think it is ok to have sex once you have a boyfriend?</b>	Yes	6	2.31 %
	No	254	97.69 %
	Total	260	100.00 %

#### 4.7.2. Risk behavior and attitudes :alcohol, drugs and other substances (n= 260)

Table 4.12 shows that 190 (73.08 %) of respondents believe that people of their age usually drink or do drug before sex and 237(91.15 %) believe that alcohol can push to have sex.

**Table 4.12: Risk behavior and attitudes of respondents: alcohol, drugs and other substances**

QUESTION ITEM	RESPONSE OPTIONS	FREQUENCY	PERCENTAGE
People of your age usually drink or use drug before sex	Yes	190	73.08%
	No	70	26.92%
	Total	260	100%
Can alcohol push to have sex	Yes	237	91.15%
	No	23	8.85%
	Total	260	100.00%

#### 4.7.3. Mean age at first sex

Table 4.13 shows that the mean age of respondents who were raped during their first sexual intercourse is 5 years lower than the mean age of those who had voluntary sex.

**Table 4.13 Mean ages comparisons of respondents who had forced sex and those who had voluntary sex.**

QUESTION ITEM	NUMBER OF RESPONDENTS	MEAN AGE	MIN. AGE	MAX. AGE
Ever had sex	16	14 years	6 years	18 years
Forced sex / Rape	5	11 years	6 years	16 years
Voluntary sex	11	16 years	13 years	18 years

#### 4.7.4. Association between type of sexual intercourse and condom use

Table 4.14 shows the association between type of sexual intercourse and condom use. The table shows that in both respondents who had voluntary sex and those who had forced sex condoms were used in most sexual intercourse. But the difference was not statistically significant (Fisher exact test P value =0.6538)

**Table 4.14 Association between type of sexual intercourse and condom use**

RESPONSES OPTIONS		TYPE OF SEXUAL INTERCOURSE		
		Forced/Raped	Voluntary	Total
CONDOM USE	Yes	3	7	10
	No	2	4	6
	Total	5	11	16

**Fisher exact test: P value = 0.6538**

#### 4.8. CONCLUSION

Most respondents demonstrated factual knowledge on HIV transmission. Although Most of participants (83.08%) show interest in taking an HIV test, in practice this is rarely done as only 22.31% of them had been tested for HIV. Hospital and clinic are mostly known by respondent for providing HIV testing. Most respondents noted the importance of consistent condom used, but expressed lack of confidence in getting a partner or boyfriend to use a condom. Only 16 (6.15%) of respondents have ever had sex out of them 5 respondents had forced sex (rape). No statistically significant difference was noted between condom use during sexual intercourse for both those who had forced sex and voluntary sex.

In this chapter, we have presented the results of mainly descriptive statistics done. In the next chapter, we will make an interpretation of the research findings, conclusion and recommendations.

## **CHAPTER 5**

### **FINDINGS CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1. INTRODUCTION**

This chapter provides an interpretation of the findings, a general conclusion to the whole study and recommendations. The aim of the study was to describe the knowledge, attitude and risk behavior of adolescents in relation with HIV/AIDS in one “girls only” catholic schools of Manzini. Caution should be taken in reflecting on these findings, given that the research has been carried on at a “girls only” missionary school where Christian principles are strictly enforced. The results of this study can therefore not be generalized to other non-Catholic and “girls only” school in Swaziland.

#### **5.2. SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS**

The interpretation of the results obtained in this study will be guided by the following study objectives:

- Assess the knowledge adolescents have regarding HIV prevention strategies,
- Identify sexual behaviors which may increase adolescents’ risk of acquiring HIV infection
- Evaluate attitudes of adolescents that may increase their risk of acquiring HIV infection
- Determine factors that may increase adolescents’ risk of acquiring HIV infection.

We will also indicate if our findings are some way in support of any aspect of the Theory of Reasoned Action which forms the theoretical frame work of this study.

##### **5.2.1. Knowledge adolescents have regarding HIV prevention strategies**

This section we will present the findings and interpretation of the knowledge adolescents have regarding HIV prevention strategies, which is the first objective of our research study.

#### **5.2.1.1. Findings**

HIV among youth in Swaziland is commonly transmitted by heterosexual contact between an infected partner and a non-infected partner. The focus of HIV prevention programs according to the Swaziland Demographic and Health survey, is on three important types of behavior: use of condom, limiting the number of sexual partners or remaining faithful to one partner and delaying sexual debut (abstinence) (Swaziland Central Statistical Office and Macro International Inc. 2008: 205-215). The respondents were asked to list three important things they should do to protect themselves from contracting HIV. Other valid reasons like avoiding sharing sharp objects and direct contact with blood when we have open wounds were considered as valid reasons during the analysis.

Among the respondents, only 67 % of respondents knew 1 to 3 ways to protect themselves from HIV infection. An alarming 33 % did not know any way to protect from HIV infection.

. These findings are higher than the result of studies done in 2008 which found that 52 % of Swazi young people aged 15 to 24 (both sex) could correctly identify two methods of preventing sexual transmission of HIV and further reject two misconceptions about HIV transmission (WHO, UNAIDS, UNICEF, 2008:12). Although the age groups are not exactly the same, they are close enough to comparison.

#### **5.2.2. Identification of sexual behaviors which may increase adolescents' risk of acquiring HIV infection**

On this section we will present the findings and interpretation of the sexual behaviors which may increase adolescents' risk of acquiring HIV infection.

##### **5.2.2.1. Findings**

In Swaziland, heterosexual intercourse is the main mean of HIV transmission, as such; factors like having unprotected sex, early debut of sexual intercourse, forced sex (rape) are among the behavior which increases adolescents' risk of acquiring HIV infection. It should be noted that by definition sexual intercourse among never-married young people is

considered higher-risk sex according to SDHS (Swaziland Central Statistical Office and Macro International Inc. 2008: 210). 16 respondents (6.15%) declared having had sex. 11 of them (56.25 %) had it voluntarily, while for 5 (31.25 %) of them it was through forced sex (rape). These findings are very low compared to the findings of the demographic and health survey of 2008 where 69% of youth aged 15 to 24 reported engaging in higher-risk sexual intercourse in the past 12 months prior to the survey and 54% of these women used a condom. Our study found that 68.75% of those having voluntary sex used a condom which is much higher than the findings quoted above.

The mean age at which the respondents had their first sexual intercourse is 17 years; this is the first risk exposure point. Religious conviction may have contributed to the delay of first sexual intercourse, given that in Swaziland 7% of young women have their first sexual intercourse before the age of 15 years SDHS (Swaziland Central Statistical Office and Macro International Inc. 2008: 209)

Forced sex usually put victims at extremely high risk of contracting HIV due to the physical trauma generally associated to it. In Southern Africa in general forced sex is in part fuel by the myth that having sex with a virgin is a cure to HIV/AIDS (Weiss 2003:13). The number of rape cases in the study was too small 5 (31.25 %) for any meaningful analysis. Condom was not used in 3 out of these 5 cases of forced sex.

### **5.2.3. Evaluation of attitudes of adolescents that may increase their risk of acquiring HIV infection.**

This section presents the findings and interpretation of the evaluation of attitudes of adolescents that may increase their risk of acquiring HIV infection.

#### **5.2.3.1. Findings**

Attitude which can be defined as an individual's evaluative positive or negative way of responding to people, views and situations (Ajzen & Fishbein, 1980; Eiser & Pligt, 1988) can be among the factors contributing to actions. In this study, various attitudes were explored in

relation with sexual behaviour, morality and HIV/AIDS, HIV testing, HIV prevention and alcohol consumption, drug use and condom use.

In relation to sexual behaviour, 93.91 % of respondents believed that it makes a difference if sexual behavior is delayed and 2.17% believe that it is not ok to have sex once you have a boyfriend. This is a commendable attitude and may be in part due to the fact that our study population has a religious background. Unfortunately, the very small number of respondents ever having sex voluntarily 11 (4.23%) could not allow statistically relevant association to assess if it was indeed the result of the strong religious background of the respondents.

Morality and HIV/AIDS attitudes were also evaluated and 81.54% of respondents believe that HIV infection is not the result of living immoral live only and 74.23% do not believe that AIDS patients pay the price of their immoral life. This is another good attitude, which is in contrast with the common belief that in strict religious environment like this study site, the focus on good morality is to a level that students may be inclined to strong negative and judgmental attitude towards immoral ways of living. However, respondents are still reluctant in practice to go for HIV testing as a significant 27 % of respondents are afraid of the result and 18 % do not want to know their result. This shows that there still a significant level of fear and stigmatization towards HIV/AIDS issues.

In relation to HIV testing, although only 58 (22.31%) of respondents have ever tested for HIV, 216 (83.08%) expressed willingness to test for HIV and only 44 (16.92%) said that they were not willing to take an HIV test. Their main reasons being that: they are not sexually active (29.55 % of respondents) and they are afraid of the results (27.27 % of respondents). The clinic was the health facility that most of them knew as a place where HIV testing is done 145 (55.77%), followed by the hospital 135 (51.92%), then the health centre 89 (34.23%) and the VCT centre 85 (32.69%). This positive attitude toward HIV testing noted among the respondents is very encouraging given the central role play by HIV testing in the fight against HIV and AIDS. The fact that few respondents have ever tested for HIV may be explained in part by the fact that most of them 244 (93.85%) are not yet sexually active. But from the positive attitude that they have toward HIV testing, we can expect that most of them will most probably take an HIV test once they start becoming sexually active.



Having sex after alcohol consumption or intake of narcotic drugs was identified in the Swaziland demographic and health survey (SDHS) (2007:193) as risky sexual behavior. When asked if they believe that people of their age usually drink or use drugs before having sex, the majority of respondents said yes 190 (73.08%). And when asked if alcohol could make them have unprotected sex, the vast majority of them said yes 237 (91.15%). This was another positive attitude noted among the respondents.

As noted in the literature review, misconceptions about HIV prevention are widespread, and negatively affect condom promotion strategies (Kaiser Foundation: 2003: 2). Consistent condom use is one of the three main messages used in Swaziland HIV prevention strategy. Although awareness of condom use is high in Swaziland consistent condom use remain the main challenge. In the demographic and health survey,(2007;193), among those involved in high risk sexual intercourse within the past 12 months, 62.50 %of young people indicated that they had used condoms during their last sexual intercourse, but inconsistent use of condoms have been reported by NERCHA & MOHSW, (2009:vii).

Although very few of the respondents had never used contraception or birth control, 9(3.46%) probably due to the fact that most of them were not sexually active (93.85%) attitude towards condom use of the respondents was generally very positive: 259 (99.62%) of them believe that sex without condom put a person at risk of STI, HIV and unwanted pregnancy. A total of 243 (93.46%) believed that using condom was a sign of respect, caring and responsibility. However, 153 (58.85%) disagree that condoms reduce pleasure. More respondents agreed that it was embarrassing to ask or buy condoms (91 versus 81). About 71 respondents (27%) confirmed having a boyfriend. Only 33 (12.69%) of them did not discuss or feel comfortable talking about condoms or discuss about condoms use with their boyfriends; 18 (25.35%) believed their boyfriend will not trust them if they brought up the subject of condom and 24 (33.80%) believed their boyfriend would think they have other boyfriends.

Despite the positive attitude of respondents toward condom use, we can note that respondents lacked assurance in buying or getting condom and limited confidence in either

discussing condom with their partners or getting them wear a condom. As much as 152 (58.46%) expressed lack of confidence in discussing condom use with their partners. Future health education intervention could be more effective if this component of assurance and confidence creation among young student is given adequate focus. It was also interesting to note the positive attitude of the majority of students towards the need to use condom consistently, (242, 93.08%)

#### **5.2.4. Determination of factors that may increase adolescents' risk of acquiring HIV infection.**

This section presents the findings and interpretation of the determination of factors that may increase adolescents' risk of acquiring HIV infection. These factors will be mainly respondents' knowledge on HIV/AIDS related issues.

#### **5.2.5. Findings.**

The respondents demonstrated good knowledge of HIV transmission, 242 (93.08%) identified sexual intercourse as the Mean of spreading HIV, 233 (89.62) knew that HIV can be spread from an infected mother to her child and that HIV is not curable. Many respondents were also able to identify correctly some misconception about HIV transmission; 256 (98.46%) knew that HIV is not spread from sharing bath room, clothes and kissing and 205 (78.85%) knew that HIV is not spread through mosquito bite. These findings are higher than those obtained in the DHS (2007;187) where 66.7 % of young women aged 15 to 24 years knew that AIDS cannot be transmitted through mosquito bite.

In relation to condom use, 252 (96.92%) have heard about condom, and 175 (67 %) rated the utilization of condoms in preventing the transmission of STI and HIV as effective. Although almost all the respondents have heard about condoms, the proportion knowing the preventing effect of condom against HIV transmission was lower than the 85.1% obtained in the DHS (2007;185) among young women aged 15 to 24 years old.

### **5.2.6. The Theory of Reasoned Action and our findings**

The theory is well summarized by Gaston as follows “the more positive the belief a person has, the more positive the attitude this will create” (Gaston, 1994: 1391) and as we know our actions are greatly influenced by our attitude. As we have commented above, the vast majority of respondents have shown positive and supportive attitude towards people living with HIV/AIDS, HIV/AIDS testing and preventive methods such as abstinence, utilization of condoms and the avoidance of alcohol and drug consumption. However the majority of respondents had not tested for HIV/AIDS.

Although this study which was mainly descriptive in nature could not analyse some of the behavioural measurements variable in depth, we can never the less say that it is probable that on the basis of the theory of reasoned action, the positive attitude of respondents towards HIV/AIDS testing and condom use illustrated in this study will be converted in real intentions that affect their behaviour positively as many of them will start becoming sexually active. The fact that very few respondents reported ever having sex and that many respondents are ready to take an HIV test as they become sexually active may be an early indication in that positive behavioural direction. However their willingness to wear condoms may be hindered by their low level of confidence in getting their boyfriends to wear the condoms when they will start their sexual life.

### **5.3. CONCLUSION**

**The** purpose of this research was aimed at describing the knowledge, attitude and risk behavior of adolescents in relation with HIV/AIDS in one “girls only” catholic schools of Manzini. The results of this study show that respondents good knowledge in identifying HIV prevention strategies. Very few respondents reported ever having sex and most of those having voluntary sex used a condom and the mean age of the first sexual intercourse was 17years. A very small percentage of responded reported experiences forced sex. The majority of respondents showed positive attitude in relation with sexual behaviour, morality and HIV/AIDS, HIV testing, HIV prevention and alcohol consumption, drug use and condom use but a lack of assurance in buying or getting condom and limited confidence in either

discussing condom with their partners or getting them wear a condom. Respondents also show good knowledge in HIV transmission and condom use.

#### **5.4. RECOMMENDATION**

Schools generally offer a good platform to communicate HIV prevention messages with the aim of infusing positive sexual behavior. Based on the findings of this study, the researcher recommends that:

##### **5.4.1. The management of Saint Theresa's School**

- Students should be commended for the overall good knowledge, positive attitude and minimal risk sexual behavior as reported by this study.
- Students should be congratulated and encouraged to demonstrate positive sexual behavior and translate this positive attitude into good intention and good behavior as they become sexually active.
- To offer counseling and support to students who have survived sexual abuse and put in place measures to identify those at risk of sexual abuse.
- To introduce a program on self-esteem that will boost students confidence in being in charge of their sexual life when they decide to start a sexual life.

##### **5.4.2. To all those involved in the propagation of HIV prevention health messages**

To continue to spread the routine messages but consider putting an accent on building confidence and assurance of students in accessing condom, discussing condom issues with their boyfriends and not compromising in ensuring that their boyfriends wear a condom. This was the main area needing strengthening that our study identified.

##### **5.4.3. To Health facilities**

To ensure that provision is made to make youth friendly corners to facilitate access to youth for health services including contraception.

#### **5.4.4. Contribution of the study**

This study provide the first step in understanding the knowledge, risky behavior and attitudes related to condom use and other preventive strategies for learners in catholic high school of Manzini. It will also be a meaningful element for literature review for students who will like to further study in that domain in Swaziland. Following this research, there is a need to do a qualitative research to further explore the reasons why the students at St Therasa's school lack confidence and assurance to access condom, to discuss condom issues with their boyfriends and to ensure that their boyfriends wear a condom.

#### **5.5. LIMITATION OF THE STUDY**

The data collection was done by the teachers as a request of the school's management. Although there was a teacher statement (Appendix E) showing to the teachers how they should conduct the data collection, there was no meeting between the teachers and the researcher as this was declined by the school vice-principal. As a result this could have affected the way teachers introduced the research to respondents and teachers could have not explained questions clearly to respondents. Moreover respondents could have been influenced by the presence of teachers when answering the questions. Another limitation is that this sample was only limited to a town of Swaziland, this means that the results and conclusions reached cannot be generalised to all catholic high schools of Swaziland. In addition, the study was descriptive in nature and thus did not test hypotheses.

#### **5.6. CONCLUSION`**

Despite the shortcomings of this study, it can still give an overview of the knowledge, risky behaviour and attitudes of Catholic high school learners in relation with HIV, condoms use and other HIV preventive strategies. This study can help clinicians, catholic organisations and even other faith based organisations to improve their programs based on acceptable quantitative based evidence as one early scientist, Lord Kelvin in Kabikira (2010) wrote that on the need to become a good scientist, "One's knowledge of science begins when he can measure what he is speaking about and express it in numbers." The researcher thus set out to achieve the research purpose and objectives in that way.

## CHAPTER 6:

### TABLES; FIGURES; REFERENCES AND APPENDIX

#### 6.1. LIST OF REFERENCES

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## **6.4.APPENDIXES**

### **APPENDIX A**

Beatrice Virginie ZANGA BITCHONG  
UNISA student  
C/O Dr. Bitchong  
RFM Hospital  
PO Box 14  
Manzini

Date:

.....  
.....  
.....

Dear Sir/Madam,

#### **RE: REQUEST FOR PERMISSION TO DO A PRE-TEST OF MY QUESTIONNAIRE**

I am a postgraduate student of Public Health at the University of South Africa (UNISA). I have been registered since 2011. I plan to carry out a research on “**KNOWLEDGE, ATTITUDE AND RISK BEHAVIOURS OF ADOLESCENTS GIRLS IN RELATION WITH HIV/AIDS AND CONDOM USE IN CATHOLIC SCHOOLS IN MANZINI**” as a fulfillment of the requirement for a Master of Public Health. I write to ask for permission to do the research at your school, St Theresa. I will need approximately 275 students from Form I to Form V. The process will only take 30 minutes for each class.

The details of the study are explained in the abstract attached to the letter. I am hoping to commence with data collection between. The University’s Senate and Faculty’s Higher Degrees Committees have approved the study.

I look forward to your favorable consideration.  
Yours sincerely,

Beatrice Zanga Bitchong

## **APPENDIX B**

### **LETTER ADDRESSED TO PARENTS/GARDIANS BY THE PRINCIPAL**

Dear Parents, Guardians, and Students,

Our school has the opportunity to participate in a unique, optional, research survey. A single, during-the-school-day, 30-minute, anonymous, paper and pencil, multiple-choice survey is being offered to all St Theresa students from Form I to Form V for whom written parent consent **and** written student assent is received within 2 days. This research activity is approved by the University of South Africa Research and Ethics committee.

The purpose of the survey is to collect information which may help teachers, administrators, and program planners improve instruction for youth on the topic of HIV. Students are not to put their name on the survey. Choosing not to participate will involve no penalty. Likewise, if students become uncomfortable at any time while taking the survey, they may stop immediately, without any negative consequence. Completed surveys will not be shared with pastors, principals, or teachers, although the combined results and analysis of the surveys will be shared with them.

Sealed questionnaires will be available at the school office for parents and guardians wishing to see the survey. Please do not share the survey with students before they take it in school.

To participate in this unique opportunity, only three steps are needed:

1. One parent or guardian signs the attached consent form.
2. Topeka Catholic school 8<sup>th</sup>-12<sup>th</sup> graders also sign the form.
3. The signed form must be returned within a week.

I have reviewed the survey, find it to be a worthwhile endeavor, and encourage you to sign and return the attached form. Any questions can be addressed to the principal investigator, Mrs Beatrice Bitchong, [zbeavir@yahoo.fr](mailto:zbeavir@yahoo.fr), 76355754, 25054144 (H)

Thank you,

Principal

## APPENDIX C

### UNIVERSITY OF SOUTH AFRICA (UNISA) INFORMED CONSENT PLEASE RETURN THIS COPY TO YOUR SCHOOL

**PROJECT TITLE: KNOWLEDGE, ATTITUDE AND RISK BEHAVIOURS OF ADOLESCENTS GIRLS IN  
RELATION WITH HIV/AIDS AND CONDOM USE IN CATHOLIC SCHOOLS IN MANZINI.**

**APPROVAL DATE OF PROJECT:**

**EXPIRATION DATE OF PROJECT:**

**PRINCIPAL STUDENT-RESEARCHER:** Mrs Beatrice Bitchong **SUPERVISOR:** Dr IS Ziyane,

**CONTACT AND PHONE FOR ANY PROBLEMS/QUESTIONS:** Mrs Beatrice Bitchong ([zbeavir@yahoo.fr](mailto:zbeavir@yahoo.fr), 76355754, 25054144 (H)). Dr IS Ziyane ([isziyane@uniswa.sz](mailto:isziyane@uniswa.sz), Human Sciences UNISA, (09-268) 76219116 (Mobile)).

**PURPOSE OF THE RESEARCH:** The primary purpose of this research is to try to better understand the knowledge, attitude and risk behavior of adolescents that many adolescents, including Catholic adolescents, currently hold with respect to HIV/AIDS decision-making issues. A secondary purpose is to present and/or publish the findings so they can help inform other researchers and educators about the knowledge related to HIV issues and the ways in which adolescents are currently thinking about HIV/AIDS related issues.

**PROCEDURES OR METHODS TO BE USED:** Anonymous, in-school, paper and pencil multiple-choice survey which will take about 30 minutes.

**RISKS ANTICIPATED:** Potential risks include possible stress due to answering questions and thinking about experiences or decisions mostly related to risky sexual life and possible consequences and participants who may be HIV positive. In addition, participants can also experience stress from a negative reaction of the findings from the school management specifically in the case there is a high level of participants who are sexually involved

**BENEFITS ANTICIPATED:** The research will ultimately help the public better understand the attitudes, behavior and knowledge related to HIV/AIDS issues held by adolescents, including Catholic adolescents. Policy makers, catholic schools and educators may be able to take advantage of these insights to improve the quality and relevance of their policies and educational activities in a variety of such settings. Parents and community members can also use the findings of this study to improve communication related to adolescent reproductive health.

**EXTEND OF CONFIDENTIALITY:** Confidentiality will be maintained by participants' contact information being protected. Participants' names will not be linked to the survey. A number will be assigned to each participant. All records will be kept in a locked file only accessible by the primary researcher.

**IS COMPENSATION OR MEDICAL TREATMENT AVAILABLE IF INJURY OR STRESS OCCURS?:** Participants will be informed to go to the "health and support centre" for counseling in case of stressful experiences related to the study. The centre provides free services. The issue of reaction of the school administration to the findings of the study should be discussed by the researcher with the schools management with an emphasis on how they will use the findings.

**TERMS OF PARTICIPATION:** I understand this project is research, and that my child's participation is completely voluntary. I also understand that if my child decides to participate in this study, she may withdraw at any time without explanation, penalty, or loss of benefits, or academic standing to which s/he may otherwise be entitled.

I verify that the signatures below indicate that we have read and understand this consent form, and willingly agree to participate in this study under the terms described, and that our signatures acknowledge that we have received a signed and dated copy of this consent form.

PARENT/GUARDIAN NAME: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## APPENDIX D

### KNOWLEDGE, ATTITUDE AND RISK BEHAVIOURS OF ADOLESCENTS GIRLS IN RELATION WITH HIV/AIDS AND CONDOM USE IN CATHOLIC SCHOOLS IN MANZINI.

#### QUESTIONNAIRE

*Before Answering these questions, make sure that you clearly understand the purpose and the implications of the survey as explained by the facilitator. Please ask any question to clarify any misunderstanding or confusion.*

#### 1. IDENTIFICATION

Serial number:.....

Date of the administration of the questionnaire:.....

Name of the facilitator:.....

#### 1. DEMOGRAPHIC AND SOCIO ECONOMIC SECTION

1.	How old are you?	..... Years	
2.	What is your education level?	Grade.....	
4.	What is your religion? (only one answer is required)	(1) Roman catholic <input type="checkbox"/> (2) Protestant <input type="checkbox"/> (3) Zionist <input type="checkbox"/> (4) Other (specify) <input type="checkbox"/> .....	
5.	who are you living With? (you can tick one or more answers)	(5) Mother <input type="checkbox"/> (6) Father <input type="checkbox"/> (7) Guardian <input type="checkbox"/> (8) Grand parents <input type="checkbox"/> (9) Sibling <input type="checkbox"/> (10)Stepmother <input type="checkbox"/> (11)Alone <input type="checkbox"/> (12)Partner(or	

		boyfriend/girlfriend) <input type="checkbox"/> (13) Other (specify) <input type="checkbox"/> .....	
6.	Source of income for the person living with you (only one answer is required)	(1) paid employment <input type="checkbox"/> (2) self employed <input type="checkbox"/> (3) unemployed <input type="checkbox"/> (4) Other (specify) <input type="checkbox"/> .....	
7.	Type of accommodation (only one answer is required)	(1) One room <input type="checkbox"/> (2) One bedroom flat <input type="checkbox"/> (3) Two bedroom flats <input type="checkbox"/> (4) More than two bedrooms <input type="checkbox"/> (5) Other(specify) <input type="checkbox"/> :.....	
8.	Number of people living in the house (including you) (only one answer is required)	(1) One <input type="checkbox"/> (2) Two <input type="checkbox"/> (3) Three <input type="checkbox"/> (4) Four <input type="checkbox"/> (5) Five <input type="checkbox"/> (6) Six <input type="checkbox"/> <b>or more</b>	
9.	Where do you stay? (only one answer is required)	(1) Urban area <input type="checkbox"/> (2) <b>Peri-urban</b> (3) Rural area <input type="checkbox"/>	

## 2. SEXUAL BEHAVIOUR AND ATTITUDES

10.	Have you ever had sex? (only one answer is required)	(1) Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	
11.	If yes state the age of your first sexual intercourse	..... Years	
12.	If ever had sex Did your partner use condom (only one answer is required)	(1) Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	
13.	If ever had sex did your partner/boyfriend use a condom at your last sexual intercourse? (only one answer is required)	(1) Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	
14.	Type of first sexual partner (only one answer is required)	(2) Boy friend/girl friend <input type="checkbox"/> (3) Simple friend <input type="checkbox"/> (4) Relative (5) stranger <input type="checkbox"/> <b>Other (specify)</b>	
15.	How did your first sexual intercourse happen? (only one answer is required, the	(1) Desire to have sex <input type="checkbox"/> (2) Forced/rape <input type="checkbox"/> (4) Other (specify) <input type="checkbox"/> .....	

	most appropriate answer)		
16.	Have you ever engaged in sex for gain (money or other gain)? (only one answer is required)	(1) Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	
17.	Does it make any difference in your sexual health to delay sex compared to those who have an early sexual life?	(1) Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	
18	Do you think it is ok to have sex once you have a boyfriend? (only one answer is required)	(1) Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	

### 3. HIV/AIDS ATTITUDES, KNOWLEDGE AND BEHAVIOR

#### a. Knowledge about HIV/AIDS(only one answer is required)

19.	HIV is Spread through sexual intercourse	(1) True <input type="checkbox"/> (2) False <input type="checkbox"/>	
20.	HIV Spread from pregnant mother to child	(1) True <input type="checkbox"/> (2) False <input type="checkbox"/>	
21.	AIDS is a curable disease, if diagnosed in early stage	(1) True <input type="checkbox"/> (2) False <input type="checkbox"/>	
22.	HIV spread from sharing of bath room	(1) True <input type="checkbox"/> (2) False <input type="checkbox"/>	
23.	HIV spread through mosquito bites	(1) True <input type="checkbox"/> (2) False <input type="checkbox"/>	

#### b. Attitudes Towards HIV/AIDS(only one answer is required)

24	Only those people who lead immoral lives will get HIV	Agree <input type="checkbox"/> Disagree <input type="checkbox"/>	
25	AIDS patients pay the price for their immoral life	Agree <input type="checkbox"/> Disagree <input type="checkbox"/>	
26	Banning prostitution can control the spread of HIV	Agree <input type="checkbox"/> Disagree <input type="checkbox"/>	
27	Young people are the most affected and infected by HIV/AIDS in Swaziland	Agree <input type="checkbox"/> Disagree <input type="checkbox"/>	

#### c. HIV Testing

28	Have you ever tested for HIV (only one answer is required)	(1)Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	
29.	Are you willing to take an HIV test ? (only one answer is required)	(1)Yes (2) No <input type="checkbox"/>	
30.	If your response to question 33 is 'no' Why are you not willing to take HIV test? (you can tick one or more answers)	(1) I don't want to know my status <input type="checkbox"/> (2) I am not sexually active <input type="checkbox"/> (3) I am faithful <input type="checkbox"/> (4) I am afraid of the result <input type="checkbox"/> (5) Other:.....	
31.	Do you know a place where one can take an HIV test? (you can tick one or more answers)	(1) Hospital <input type="checkbox"/> (2) Clinic <input type="checkbox"/> (3) Health centre <input type="checkbox"/>	

		(4) VCT centre <input type="checkbox"/> (5) Other:..... .....	
--	--	--	--

**d. HIV Protection**

32.	list 3 important things you should do to protect yourself from contracting HIV	..... ..... ..... ..... ..... ..... .....	
33.	People of your age usually drink before having sex? (only one answer is required)	(1) True <input type="checkbox"/> (2) False <input type="checkbox"/>	
34.	Do you believe alcohol can push you to have unprotected sex? (only one answer is required)	(1) True <input type="checkbox"/> (2) False <input type="checkbox"/>	

**4. CONDOM USE: ATTITUDES, KNOWLEDGE AND USE**

35.	Have you ever heard of condom (only one answer is required)	(1)Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	
36.	Have you ever used contraception or a birth control? (only one answer is required)	(1)Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	
37.	How will you rate the utilization of condoms in preventing the transmission of STD and HIV (only one answer is required)	Effective <input type="checkbox"/> Non effective <input type="checkbox"/>	
38.	Sex without condoms put a person at risk of HIV (only one answer is required)	(1)Yes <input type="checkbox"/> (2) No <input type="checkbox"/>	
39.	Sex without a condom once in a while is not a risk for HIV infection" (only one answer is required)	Agree <input type="checkbox"/> Disagree <input type="checkbox"/>	
40.	Using condoms is a sign of respect, caring and responsibility (only one answer is required)	Agree <input type="checkbox"/> Disagree <input type="checkbox"/>	
41.	Do you talk about condoms use with your boyfriend? (only one answer is required)	(1)Yes <input type="checkbox"/> (2) No <input type="checkbox"/> (3)Don't have a boyfriend <input type="checkbox"/>	



42	Do you feel comfortable to discuss about condom use with your boyfriend (only one answer is required)	(1)Yes <input type="checkbox"/> (2) No <input type="checkbox"/> (3)Don't have a boyfriend <input type="checkbox"/>	
43	How do you think your boyfriend will react if you "bring up" the subject of condoms? (you can tick one or more answers)	He/she will not trust you <input type="checkbox"/> He/she will think that you have other boyfriends or girlfriends <input type="checkbox"/> Don't have a boyfriend <input type="checkbox"/> <b>Other (specify)</b>	
44	Condoms reduces pleasure (only one answer is required)	Agree <input type="checkbox"/> Does not agree <input type="checkbox"/> <b>Other (specify)</b>	
45	It is embarrassing to ask/buy a condom (only one answer is required)	Agree <input type="checkbox"/> Disagree <input type="checkbox"/> <b>Don't know</b>	
46	What is your level of confidence in getting your partner to wear a condom (only one answer is required)	Very confident <input type="checkbox"/> Somewhat confident <input type="checkbox"/> Not confident at all <input type="checkbox"/> Don't have a boyfriend <input type="checkbox"/> <b>Other (specify)</b>	

## APPENDIX E

### TEACHERS STATEMENT FORM

Saint Theresa teachers will administer a single, 30-minute, anonymous, paper and pencil/pen multiple-choice survey to all St Theresa High School students from Form I to Form IV. Please teachers could you explain the following to pupils:

- The primary purpose of this research is to try to better understand the knowledge, attitude and risk behavior of adolescents that many adolescents, including Catholic adolescents, currently hold with respect to HIV/AIDS decision-making issues. A secondary purpose is to present and/or publish the findings so they can help inform other researchers and educators about the knowledge related to HIV issues and the ways in which adolescents are currently thinking about HIV/AIDS related issues.
- Completed questionnaires will not be shared with priests , principals, or teachers, although the combined results and analysis of the research will be shared with them. Any questions can be addressed to the principal researcher Mrs Beatrice Bitchong [zbeavir@yahoo.fr](mailto:zbeavir@yahoo.fr), 76355754, 25054144 (H).
- Do not write your name on the questionnaire
- Do not look at what someone else has written
- I as your teacher will not look at your answers
- If you tick “others” item, please specify
- On question 30 “if your response to question 33...” replace 33 by 29
- You can tick more than one item if you think it is appropriate for your case.
- Each question and item should be explained to the students

After filling up your questionnaire, please make sure you bring it back to me recto verso. The questionnaires will be put immediately in the brown envelopes. After receiving all filled questionnaires, they will be put in the big black plastic and sealed before dropping it at the vice principal office.

The teacher will put all the filled questionnaires back to the brown envelope and leave to the school secretariat.

Thank you so much teacher, may God bless you.

## APPENDIX F:

### Electronic confirmation of the research permission

**From: Saint Theresa High School**

To Meisziyane@uniswa.sz

Jul 24

Dear Beatrice, Supervisor

This note serves to confirm that above mentioned has been granted permission to a research in our school. An appointment has been arranged for the 9th August 2013 so that she could meet career guidance teachers who can help her out in administering the questionnaire on the 12<sup>th</sup> of august.

Thank you

Kind regards

Mr. Albert Sihlongonyane  
Headteacher St. Theresa`s High School  
[Reply](#), [Reply All](#) or [Forward](#) | [More](#)

